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CIS

HOSPITAL CARE AND MEDICAL SERVICES TO ELIGIBLE VETERANS IN THE STATE OF FLORIDA

HEARING

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

JUNE 23, 1982

Printed for the use of the Committee on Veterans' Affairs

Serial No. 97–69

U.S. GOVERNMENT PRINTING OFFICE
97-289 C WASHINGTON: 1982

H761-32

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HOSPITAL CARE AND MEDICAL SERVICES TO ELIGIBLE VETERANS IN THE STATE OF FLORIDA

WEDNESDAY, JUNE 23, 1982

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. Ronald M. Mottl (chairman of the subcommittee) presiding.

Present: Representatives Mottl, Edgar, Mica, Hammerschmidt, Solomon, Smith of Alabama, Napier, McEwen, and Dunn.

OPENING STATEMENT OF CHAIRMAN MOTTL

Mr. MOTTL. The Subcommittee on Hospitals and Health Care will come to order.

We are conducting an oversight hearing this morning to hear testimony on the provision of hospital care and medical services to eligible veterans in the State of Florida. Our subcommittee hopes to learn how well the Veterans' Administration's Department of Medicine and Surgery is meeting its obligation to provide quality care to these veterans.

As members of the Florida congressional delegation know, there are tremendous numbers of veterans moving into their State each month. Most of these veterans are older, retired persons seeking the climatic and recreational advantages of the Sun Belt, although there is also a significant number of younger veterans among these immigrants.

The committee receives many complaints from veterans and their families regarding the provision of medical services when they move to Florida. A typical complaint cites the fact that hospital care and medical services were provided to the veteran by the VA prior to his move to Florida. When the veteran seeks VA medical care at his new residence, he is told that a bed is not available or an appointment for an out-patient care or examination is scheduled so far in the future that the veteran simply cannot wait.

My friends and colleagues, Congressmen Claude Pepper and Dan Mica, have discussed with me the many complaints they receive regarding the health care of veterans in Florida. I know the entire Florida delegation has a deep concern and interest in this vital matter.

We hope to learn this morning precisely what the problems are, what the VA plans are for meeting these demands for health care

of veterans in Florida, and any suggestions the witnesses may have for providing quality and quantity health care required by veterans in this State.

Before I call the first witness this morning, I would like to recognize the distinguished ranking minority member of the subcommittee and the full committee, the Honorable John Paul Hammerschmidt, for his opening remarks. John Paul, before you comment, I want to say what an outstanding job you have done for the veterans of this Nation. Our committee is probably the most bipartisan body in the legislative branch. This is due in large measure to your leadership and statesmanship, and I want you to know how much I appreciate the assistance you have given me on this committee.

The benefit programs a grateful Nation provides its veterans contain the mark of your dedication to the veterans' cause.

John Paul, do you have any comments at this time?

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Mr. Chairman, I appreciate your very kind and complimentary remarks. They are especially gratifying coming from a chairman whose accomplishments as a leader of this committee are so extensive. Those accomplishments will reach into the lives of all American veterans who find it necessary to seek medical care from the Veterans' Administration. So you can be very proud of your fine record in this committee, Mr. Chairman. It will never be forgotten.

Mr. MOTTL. Thank you.

Mr. HAMMERSCHMIDT. You know, we are dealing with a most difficult problem here this morning. The migration of older veterans into Florida inevitably increases the need for VA medical facilities to take care of their health needs. Yet a general medical and surgical hospital cannot be erected, equipped with the complex and highly expensive apparatus required for the practice of modern medicine and staffed by qualified medical personnel, in a matter of weeks.

Yet the dimension of the problems is increasing weekly, and I understand almost even daily. The present mobility of our veteran population has brought about conditions that perhaps were not adequately appreciated when the present system of 172 VA hospitals was being constructed, and this expanding migration has come about as many among the largest group of our veterans' population, those veterans from World War II, have begun to reach retirement age and have moved to the more moderate climate of Florida.

It is only natural, of course, that they expect the same service from the VA health care facilities there that they received in their home States. But the Florida hospitals and clinics have been pushed far beyond their capacities.

While nonservice-connected veterans have been treated on a space-available basis back home, Florida VA medical facilities are hard pressed to take care of many of them because service connected veterans of course, have priority. So the questions that we must explore today concern the state of the Vetarans' Administration planning for the present veteran population of Florida, and the

continued veteran influx into that State that can be expected in the years ahead.

Mr. Chairman, because of the very distinguished panel of congressional colleagues I see on our witness list, certainly including Senator Paula Hawkins I see out there, and Bill Young who serves on the Appropriations Committee that deals with the Veterans' Administration in the House, and our colleague, Senator Pepper, coming in, because of all these fine witnesses, I regret that I am going to have to leave these hearings fairly early to go to a markup session on another subcommittee on which I am ranking member. So I am sure they will understand, but I am looking forward to hearing the witnesses who will testify before I leave and I wish I could stay to hear all of them.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you, John Paul.

Due to the large number of members from the Florida delegation who desire to be heard this morning, it is my plan to deviate from our normal hearing procedure. I would like to ask our distinguished colleague from Florida and one of the leading members of this subcommittee, Dan Mica, to take a seat at the witness table and present his opening statement on the difficulties of providing quality care to eligible veterans in the State of Florida.

Following his statement, I would just ask that he remain at the witness table and moderate the panel of members from his wonderful delegation.

Before we introduce our distinguished colleage, Mr. Mica, for his opening remarks, I would like to welcome Senator Hawkins, Senator Chiles, the Honorable Bill Chappell, not only a great Congressman, but also a great manager of the Democratic baseball team, the Honorable Don Fuqua who has distinguished himself as the head of the Science and Technology Committee, Earl Hutto, a great Congressman from Florida, and we have Bill Nelson who has distinguished himself from that delegation, and Representative Claude Pepper is here with us, and Clay Shaw, Representative from southern Florida, and Bill Young, our distinguished Representative from the Appropriations Committee.

I want to welcome all of you here this morning, and your entire statements will be submitted into the record without objection.

Without further ado, I would like to introduce at this time for his opening statement on behalf of the delegation Mr. Dan Mica.

STATEMENT OF HON. DANIEL A. MICA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. MICA. Thank you, Mr. Chairman.

Before I take the Chair, I would first like to say I, indeed, do thank you for holding this hearing on the specific needs of Florida veterans. It is very unusual, and I do not recall ever seeing the committee hold hearings for a specific State, but we have a special problem with the type of growth and with the type of problems we have and with the statement from the VA that Florida will lead the Nation and be a demonstration State in the Nation, it is well planned that we look into our problems because if we cannot solve

them in Florida, certainly we will face them in the future in the Nation.

Mr. MOTTL. It was due to the great influence you have with this committee.

Mr. MICA. Well, I do appreciate that. Again, before I take the Chair, I will withhold most of my comment until after all of my colleagues from Florida have had an opportunity to present their testimony, and without objection, I would like unanimous consent that each Member have 5 days to submit any additional information for the record.

Mr. MOTTL. The Chair hearing no objection, it will be so ordered.

Mr. MICA. May I invite Senator Hawkins, Senator Chiles, Senator Pepper, any members of the Florida delegation to join me at this time, and we will introduce each as they come in.

Mr. MOTTL. Sure. We have Mr. Young up here, and Mr. Clay Shaw.

Mr. MICA. Mr. Chairman, I might also point out that several Florida Members have conflicting committee meetings, so they will be coming and going at different times.

Let me just say again that I do appreciate your willingness to have this hearing. Florida has over 1.3 million veterans, and that is projected to increase to over 2 million veterans by 1990.

I think the key to this entire hearing is simply that the trend in Florida is totally different than that in the United States. Between now and the year 2000, the number of veterans in the entire United States will be reduced by 10 percent. In Florida, the number of veterans will increase over 100 percent. The problems are starting to become very clear.

The Miami clinic—we have the director here—was designed to handle 135 patients a day, their outpatient facility. They are now treating over 1,000 a day.

In my testimony, as I close this hearing later today, we have a list of statistics like that that are all over the State of Florida, and at this time I will withhold my testimony, and I would like to introduce our Senator from the State of Florida, Senator Paula Hawkins, for any comments she may wish to make.

[The prepared statement of Mr. Mica appears on p. 35.]

STATEMENT OF HON. PAULA HAWKINS, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator HAWKINS. Thank you so much. It is a great opportunity to be here, and we certainly do thank you for holding this hearing.

As Congressman Mica has said, Florida has particular problems, many problems, veterans being just one of them, and we certainly do appreciate your attention to this, and as he has said, I would just like to restate what he has said, that the current estimates indicate that veterans are moving to Florida at a rate of 5,000 per month. To me that is just overwhelming. Veterans around the country are entering retirement and selecting Florida as their retirement home.

We have done a wonderful job selling people that Florida is the place to retire because of the good weather and the other comments that you made in your opening statement, and they have de-

cided to come to Florida in their closing years to live in comfort, and where the national veterans population is expected to decline from 10 to 12 percent by the year 2000, it seems a long way away until we try to make plans, as you are here today.

The population in Florida is expected to increase by 100 percent. In the next 20 years, the overall veterans population is expected to decline, but the veterans population in Florida is expected to double. In practical terms, this means that because veterans are migrating to Florida in such large numbers, beds will stand vacant in some parts of the country, while Florida and some of the other Sun Belt States will suffer from chronic hospital bed shortages.

The problem is being aggravated by the graying of the veteran population. As this population ages, it is placing a greater demand on the health care services provided by the Veterans' Administration.

Estimates reveal that in the critical veteran population aged 65 to 74, the nationwide population is expected to increase by 168 percent. This startling increase in this high cost age group is paled by the expected 550-percent increase for this same age group in Florida. For those 75 years and older, the expected increase is 755 percent.

For the Nation as a whole, this means that while the veterans' population is shrinking, the health care required for the remaining population is more extensive and much more expensive. But in Florida this means that the veteran population is both growing at a phenomenal rate and is comprised of an increasing number of veterans requiring the most costly services.

In order for the VA to cope with the fast growth areas of the country, planning must begin now. Hospital facilities, nursing facilities, outpatient clinics and so forth cannot be added overnight. It takes time to construct, equip, and man these facilities. The needs of the States like Florida must be anticipated and not put off until we find ourselves in the midst of a full blown health care crisis.

If we do not have the vision to look ahead and prepare for these problems, Florida's anticipated veteran population of 2.6 million in the year 2000 will be faced with inadequate, substandard health care. I believe our veterans deserve better than this.

Reliable, decent health care is one of the areas in which I will not compromise.

While Florida is facing a long-term catastrophe if more resources are not channeled to care for Florida's expanding veteran population, our State is now beginning to face a serious short-term problem caused by the same factors: overcrowding, understaffing, and a shortage of needed equipment is all too familiar in Florida's VA facilities.

For example, the Miami hospital facility is currently handling almost seven times the outpatient services that it was designed to handle. Although the VA has opened two other outpatient clinics in south Florida, demands on these facilities is growing daily. The State of Florida estimates that by 1990, Florida's VA system will require the capability of handling an addition 685,034 outpatient visits.

In addition to the problems projected for outpatient care, the State of Florida projects that it will require over 2,300 more inpa-

tient facility beds to be able to cover the demand by 1990. This represents an increased need of 78 percent in only the next 8 years.

This sharp increase in the need for inpatient facility beds is caused not only by the increase of the veteran population, but also by the fact that the increasing age of the population results in longer stays in the hospital and, hence, a greater demand for beds.

Furthermore, Florida faces tremendous demands for more long-term psychiatric beds and additional facilities for veterans' nursing home care.

Mr. Chairman, the veterans of Florida face a grave future regarding veterans' health care unless we have the vision to act now to begin approving the construction of medical facilities now. I urge this subcommittee to begin considering, which you are doing, before it is too late the urgent needs facing our State, Florida. Thank you so much.

Mr. MOTTL. Senator, thank you for your outstanding statement this morning, and it certainly will contribute a great deal to the subcommittee here. Mr. Mica, do you want to introduce our next witness to the subcommittee then, please?

Mr. MICA. Thank you, Mr. Chairman.

Mr. MOTTL. We will hold all questions in abeyance until the entire delegation has spoken.

Mr. MICA. At this time, if I may repeat, as Florida Members come into the room, we will have each of them come to the table, but at this time I would like to introduce our senior Senator, Senator Lawton Chiles.

Mr. MOTTL. Senator Chiles, welcome to the subcommittee this morning.

Senator CHILES. Thank you, Mr. Chairman.

Mr. MOTTL. I am looking forward to your statement.

STATEMENT OF HON. LAWTON CHILES, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator CHILES. I am delighted to have the opportunity to be here, and I want to commend Congressman Mica for seeking this hearing and certainly this subcommittee for giving us the opportunity to talk to you some about Florida's problems. I think every time any one of us in the delegation goes home, we continually confront veterans who talk to us about the problems that they are having in trying to seek medical outpatient care and any kind of care from our veterans' facilities. The frustrating thing these veterans keep telling us is, "Back where I came from," and whether that is Kansas or Minnesota, or wherever they could go and receive care very quickly, whether they are service connected or nonservice connected; whether it is outpatient care they are seeking; whether it is drugs or prescriptions they are seeking. Then they come to Florida, and suddenly they cannot understand why they have to be put on long waiting lists. If they are nonservice connected, many times they are simply turned away because they cannot be served. If they are service connected, even seeking surgery, they find that they face long waits or long schedules. Of course, this kind of situation is just growing more and more severe as we have the tremendous increasing number of veterans coming to the State

of Florida. I know you are hearing a lot of statistics today, but 5,000 veterans are moving to Florida every month, and that number is just compounding the existing problems we have.

We recognize that this is a problem that has not just sneaked up on us, and of course, we have been trying to talk to the VA about it for a long period of time, and we have been able to receive some additional outcare facilities. We are delighted to be able to receive those facilities, but we are still so far behind with the 5,000 veterans that are showing up every month that we must figure some way to deal with that. We recognize that we are facing a particular shortage of budget funds at this time. But it seems, Mr. Chairman, we should really seek a more fair apportionment of funds and not have to wait 10 years for a census to come up and then find that census is outdated by the time that it goes into effect, to see any reallocation of funds. As veterans are moving out of the other areas, we recognize that they are leaving in some instances facilities that are not fully being utilized. Maybe there is nothing you can do about the utilization of those facilities, but some of the dollars should flow with the veterans for the treatment of those veterans.

Congressman Mica and I have introduced some legislation to try to get the VA to compile more up-to-date figures and to use these up-to-date figures as a basis of trying to determine what the real needs are, and we certainly hope that the subcommittee will look at that legislation. For example, the VA can tell us how many visits in an outpatient facility were made in the past year. They can tell us how many people were treated, but to me one of the most telling statistics we could have and the one that they cannot give us is how many people sought treatment. How many people were turned away? How many people have to wait? How many people did not get served?

That, somehow, is the statistic the VA says we do not compile. So, of course, we in Florida feel that with that kind of statistic we would be able to show some of the tremendous needs that we actually have. As I say, we recognize that these are tough times in which we now live, but we feel that there should be a fair apportionment of the dollars. We are delighted that the subcommittee is looking at this important question and would give us the time for this hearing.

Mr. MOTTL. Thank you very much, Senator Chiles, for your excellent statement, and it will also contribute a great deal to the testimony of this morning.

[The prepared statement of Hon. Lawton Chiles appears on page 31.]

Mr. MOTTL. Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman, and let me thank both of our Florida Senators. I might say that they have expressed numerous times their concerns over the needs of Florida veterans in their recognition of this problem. If I may just comment, Senator Chiles has raised a question that I hope to raise with the VA officials that are here this morning, statistics. We were turned down for 4 straight years to receive a new clinic in Broward County based on statistics that indicated there were not enough veterans living in Broward County until we checked the Miami records and found out

that there were actually more veterans being treated from Broward County than they actually had living in Broward County in the records that they gave us. So the fact is if those were just being treated, the numbers are far greater. We did get an update, but we are wondering, with the statistics we see, the problem is bad. With updated and more accurate statistics, it may be a lot more severe. Thank you, Senator Chiles. At this time I would like to call on my colleague, Congressman Bill Young, who has been a great help and helped us get funds for some of our studies in areas for the veterans of the State of Florida. Congressman Young.

STATEMENT OF HON. C. W. BILL YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. YOUNG. Thank you, Congressman. Thank you, Mr. Chairman.

Mr. MOTTL. Welcome, Bill.

Mr. YOUNG. Thank you very much.

Mr. MOTTL. It is a pleasure to have you here this morning.

Mr. YOUNG. Well, I appreciate the opportunity you have given me and all the members of the Florida delegation, and I want to thank each of you for the work that you have done to help us recognize the debt that every American and every person living in a free world today and enjoying the liberties that were provided for him or her by those people who served in our armed services has to veterans. We recognize that debt, and we have written much of that responsibility into the law, and you gentlemen have had a lot to do with that, and I am happy that my Subcommittee on Appropriations has been working very closely with you in that regard because we try to meet our obligation to these veterans. You are going to hear much of the same information said in different ways here this morning, but the fact is those 5,000 new veterans coming to Florida every month, are coming from somewhere. They are coming from Ohio, for example, Mr. Chairman; and they are coming from Pennsylvania, Mr. Edgar; and they are coming from New York, Mr. Solomon; and they are coming from Arkansas, Mr. Hammerschmidt; and they are coming from all over the United States, and we are happy to have them. I am sure that you are as anxious as we are to make sure that they get as good care in as capable a facility in Florida as they would back in your home State. It has been a problem. The large veterans' growth was, I think, unanticipated. We did not realize we were getting as many veterans moving into Florida every month as we are. In the Tampa Bay area, where I have the privilege of serving, is the center of the veterans' population in the State of Florida, and that is why the regional offices are located there. The newest veterans hospital in the Southeast is located in that part of the State, and we are proud of what has been done by this Congress in behalf of the veterans. But as those veterans come to Florida, there are problems. As the funds are allocated throughout the Nation based on the veterans population in a given State, unfortunately we have not effectively taken into account the tremendous immigration into the State of Florida from other States.

The Veterans' Administration now has undertaken a new program known as the medical district initiated program planning, which we believe will be very helpful in establishing what this transitional flow should be.

Many of these folks who come to our State, who we are very happy to have, Mr. Chairman—but many of them are reaching retirement age. The average veteran's age in Florida today is 62.6 years of age. That means they are less than 3 years away from being eligible for total free medical care, whether that medical requirement is service connected or not.

This means the tremendous burden that is going to be placed on the existing facilities in Florida is going to be unreal if we do not move rapidly. We have provided new out-patient clinics in Broward County, for example, in Lee County for another example. We are attempting to get additional out-patient clinics in other parts of our State, and the new hospital at Bay Pines which is almost complete.

But even if we have the facilities, if we do not have enough people to staff them and if we do not have enough technicians and therapists and doctors and nurses, we have a real problem in providing the proper care.

The lines of veterans waiting to get into our facilities are very long, and they will become much longer in the very near future if we do not make provisions now, and I know that you all are very much aware of this problem, and I know of your dedication and your commitment to making sure that it does not become a very serious problem and that we resolve it now. I have a rather lengthy written statement that I would like permission to submit for the record.

Mr. MOTTL. Without objection, it will be included.

[The prepared statement of Hon. C. W. Bill Young appears on page 32.]

Mr. YOUNG. Again, I want to thank you for the opportunity to testify this morning, and I want to thank you for the good relationship we have enjoyed, your committee in relationship to my Subcommittee on Appropriations, and I think we all have some good reason to be proud of a job that Congress and our Government has done and will continue to do in behalf of the veterans of our country, those people who have made it possible for us to be here today as free people in a free society, taking part in a representative Government. I thank you very much, Mr. Chairman.

Mr. MOTTL. The Chair would like to thank you for your great statement this morning and your contribution on the Appropriations Committee, Mr. Young. You have done a great job for it. Mr. Hammerschmidt, did you want to say something?

Mr. HAMMERSCHMIDT. Mr. Chairman, as I mentioned earlier I am going to have to leave for a markup, but I want to express my appreciation to the entire Florida delegation. They are an unusual delegation and a powerful group of people. I especially want to single out Bill Young because he has worked so closely with our authorizing committee on his Appropriations Committee, and I know that Bay Pines nursing home, domicilary, and hospital probably would not be there if it were not for his work.

I just want to single out one other Member because it has been my great pleasure to work with him for so many years, ever since he has been on the Select Committee on Aging and serves as its distinguished chairman, and because I will not be here to question him or have any colloquy with him later, I want to express my appreciation for what we refer to as "Senator" Claude Pepper for the great work he does because his work on the Select Committee on Aging is so closely affiliated and alined with what we are attempting to do here, to hear the needs of the State of Florida. So I want to express my appreciation that he is here today.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Hammerschmidt.

Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman.

Thank you, Congressman Young.

As I introduce our Senator Pepper from Florida, I would like to simply say this. I told the committee that the nationwide veterans population would be reduced by 10 percent between now and the year 2000. Florida will have a 100-percent increase.

Let me say that in the age bracket of 65 to 74, the senior veteran, we expect by the VA's own figures to have over a 550-percent increase in that period of time.

The chairman of the Select Committee on Aging and our Senator Claude Pepper is very, very capable and able to speak on this subject.

Mr. MOTTL. Senator Pepper, we want to welcome you here this morning, and I want to echo the remarks that my distinguished colleague, Mr. Hammerschmidt, made.

Mr. PEPPER. Thank you.

Mr. MOTTL. We look forward to your testimony this morning.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PEPPER. Thank you very much, Mr. Chairman.

Mr. Chairman, may I say in my opening remarks that as one grows up into the upper years' life, he has a certain nostalgia. He looks for the old names that he was familiar with in the field of baseball, for example. I turn back to Ty Cobb and Babe Ruth, to Evers, to Tinkers and to Chance and the like.

But I had a refreshing recapture of the memories of my youth Wednesday evening of last week. On the mound pitching to a great victory for the Democrats I saw all wrapped up in the chairman today Rube Walker, Walter Johnson, and Christie Mathewson in Mr. Mottl.

Mr. MOTTL. Thank you very much, Senator Pepper. I cannot win elections, but I can win baseball games. You have the other side of the battery sitting next to you, Mr. Chappell.

Mr. PEPPER. With our captain here of whom we were very proud. Mr. Chairman, I wish to thank very deeply you and your distinguished committee, and especially our distinguished chairman and our colleague from Florida of the subcommittee, that you experience the passion and the concern that this hearing and your other great work evidence for the veterans of our country. Of course, we

all know that Abraham Lincoln said, "Let us bind up the wounds," of the Nation and "care for him who shall have borne the battle," and I think no grateful nation can do less than care for him who have borne the battle or else who offer himself in his country's service. Every one of us knows that when we go home we have a great number of telephone calls and sometimes personal visits from veterans pleading to get into the veterans hospitals or pleading to stay in the hospital because they do not have a nursing home to which to go, and if they did, they do not have the money to pay for being kept there, and the wife will call in tears and say, "What am I going to do? They tell me my husband has got to get out of the veterans' hospital. I have no money to put him into a hospital for nursing care or in a nursing home where it will cost above $1,000 a month ordinarily to care for him. What am I going to do?" she asks us. Well, of course, that is the problem.

I know we are very proud of the quality of service, the excellence of administration of our veterans' hospital, which is in my district in Miami, and I am very proud of it, but I have been out there several times, just sometimes to visit my brother and other times to visit others who were there. At nighttime I have heard men screaming out for care when there were not nurses to give that care, and on my way out I stopped at the nurses' desk and said, "How many nurses do you have on duty here?" I have forgotten the exact number they told me in a big ward, but she told me how many patients she had to look after. She said we just cannot go to all the cries that come out for help because we do not have the staff. They have cut our staff so much. I just cannot believe that our country would want to show what amounts, in substance, to ingratitude to that veteran by saying we do not have money enough to have nurses enough to help you when you are in pain. We do not have facilities enough to take care of you when your family has no way to take care of you, and you need to continue under the sort of services that you are receiving here. We do not have enough for long-term care. We have got a few ambulatory homes, but we do not have near enough long-term care facilities for veterans that are maybe—some of them are mobile and ambulatory. But we need a place where veterans of this country, if he cannot live by his own support, if he does not have family support, should not be an object of charity, but should have a place that his country has provided for him where he can live in dignity and decency for the last years of his life. So we need, of course, more long-term psychiatric care beds. We need additional nursing home space, and we need more out-patient care for veterans. So I would never vote to cut the appropriations for veterans in this country unless it could be shown that there was inefficiency, or waste, or corruption, or something and we did not need the funds.

Now, my colleagues have already pointed out here about how much our own veterans population is increasing and how rapidly. Five thousand veterans are coming each month. We are glad to have them come. It is an honor to be host to the veterans of this country, and we are proud to have them come. But what do we do if we do not have the facilities for them? Do they have to turn around and go back home or do they just have to suffer? So I commend you in the warmest way, Mr. Chairman and Mr. Mica, of

whom we are very proud, who has been a magnificent leader for service for the veterans. We commend you both and your committees, but we hope you will recognize our particular situation in Florida where we are the recipient of a disparity of the share of the veterans population of the country especially, shared by many other parts of the country. I will just add this, Mr. Chairman, in conclusion. We would put a fellow in jail for not only being unpatriotic, but for retarding the enlistment of veterans and retarding progress of this country's preparedness and defense. If a man stood at the recruiting desk, recruiting office, or if a man stood at the induction center and said,

> Listen now. Remember, old fellow, when you get home, if you get back, you are probably going to have a hard time. You are not going to get all of the medical care that you need. You may not be able to get a job. We just want you to know, old fellow, that you are going on a mission, but when you get back, you are going to have a mighty hard time.

We would put a fellow like that in jail if he was saying that to veterans, men coming into the service. That is the truth, and we ought not to let it be the truth. So I want to commend you. I have a statement here for the record.

Mr. MOTTL. Without objection, your testimony will be submitted to the committee.

[The prepared statement of Hon. Claude Pepper appears on page 33.]

Mr. PEPPER. I commend you on what you have done.

Mr. MOTTL. Thank you for your outstanding statement. I agree that priority for the veterans should have the same priority for our national defense. If we have a Volunteer Army and voluntary service, how can we say to these young men and women that are going into the service that we are not going to take care of you after you have given service to the country? So we should put this on the same strata and the same priority as our national defense.

Mr. PEPPER. I would agree with that.

Mr. MOTTL. I would hope that the administration and the Congress would see to it that this will be done.

Mr. PEPPER. Thank you, Mr. Chairman.

Mr. MOTTL. Thank you.

Mr. MICA. Thank you, Mr. Chairman, and thank you, Mr. Pepper. Let me repeat for my colleagues from Florida who have come in since we opened the hearing that we have extended the record 5 days for any comments or additional information that anyone would like to submit, and at this time I would like to introduce my colleague from Broward County, Fla., a Congressman who is from a different party, but we put partisanship aside when it comes to veterans. Broward County is one of the most rapidly growing communities and counties in the State of Florida, with one of the fastest growing veterans populations. Congressman Clay Shaw and I have had an opportunity to work together and serve veterans, and he has done a magnificent job, and we are very pleased to have you here.

Mr. SHAW. Thank you, Dan.

Mr. MOTTL. Welcome, Clay, and your entire statement will be submitted into the record without objection.

[The prepared statement of Hon. Clay Shaw, Jr. appears on page 34.]

STATEMENT OF HON. E. CLAY SHAW, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. SHAW. Thank you. I am going to submit my written statement.

Mr. MOTTL. It is a pleasure having you here.

Mr. SHAW. I will be mercifully brief, however, in my testimony here this morning. I have found one thing of great interest at the significant victory of the Democrats last week in the congressional baseball game. It becomes more significant with every one of Congressman Pepper's speeches. I feel that it is going to be a long year for us Republicans unless we are successful next year in overcoming that initial defeat. Mr. Chairman, you and I have spoken on several occasions with regard to the veterans facilities. I know of your concern for your own constituents who travel down to South Florida and who knows there are probably many of the members of this very fine committee who might some day, and I would say statistically quite probably will, be seeking veterans assistance in my home district of Broward County. So I would say in looking at the facilities and looking at these statistics that you are receiving here this morning that you might very well be part of these statistics, and I think this is something that you should consider not only for your constituents who are going down to our part of the country, but also for perhaps yourself and members of this committee. I would like to compliment you on holding this hearing, on seeing the significance of the problem in Florida. Every member of this committee, you, Mr. Chairman, and I of course have a special debt of gratitude to Congressman Mica who has been of great assistance to me as a freshman in learning the problems of the veterans and of course his good work in Broward County, which overlaps in our shared congressional district of Broward County. In my prepared statement I have been quite critical of the facility in Dade County, Fla., but I would like to clarify that in a particular way, and I think it is most significant that my testimony would follow that of Congressman Pepper in this regard. There have been many, many occasions of rudeness and occasions of lost records and occasions for mixups. Now, I do not blame the administration of the hospital for these shortcomings. I blame the overwhelming case load that this hospital has to work under. You have already heard the statistics as to how overworked the facility is. I do not think that any of us could possibly put up with this type of treatment if we could possibly afford other treatment elsewhere, but there are long waits of elderly, of sick. There are situations where people should be getting into the hospital who simply cannot get in there because of the long waiting lines. There are a tremendous number of situations where we have heard that people are handled rather abruptly on the telephone, and they get there and wait in these awful long lines, and they are treated not like human beings, but as numbers. I think this is wrong, but I am not sure that there is any way to overcome this very serious situation except by supplying adequate facilities. We are in a situation now where we are far behind, and

we are getting further behind. We have to look to, I think, a most significant investment in south Florida to get over this tremendous hump that we have to get over before we even catch up. As has been told to this committee many times, and I am sure many times more, this population is increasing at 5,000 per month. I would guess that just a proportionate part of that number is coming into south Florida, which is going to even make a facility that is very short-handed now in worse condition. I would like to, in closing, simply thank this committee again for addressing the problem. I know you are very much aware that the problem does exist in south Florida, and I would certainly invite you to continue your very fine efforts to remedy a situation in which we are only in the perhaps first stages of the acute problems that are going to exist. Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much for your fine statement this morning, Mr. Shaw. I really appreciate your contribution to the subcommittee. Thank you.

Mr. EDGAR. Mr. Chairman.

Mr. MOTTL. Yes, Mr. Edgar.

Mr. EDGAR. Unfortunately I am on the same committee that John Paul Hammerschmidt is on and have to go over to Public Works for a markup, and if I could I would like to interrupt for a second and just make a couple of comments and commend my colleagues from Florida who are coming and making a persuasive case for the need for additional medical facilities and hospitals and health care facilities for the aging population and the increasing population in Florida.

Claude Pepper was here, and I unfortunately had to go out for a telephone call, but Mr. Pepper has introduced legislation, actually a resolution, which I have cosponsored expressing the sense of the House to maintain VA medical services for the veterans over age 65, and as he makes the case very often, and all of us are aware, the aging population of this Nation needs a great deal of care and service, and in Florida you have the focal point of many of those aged veterans.

You point out the increase in population of veterans in Florida. I think that is important. I hope that you will also recognize that in some of the areas where veterans are leaving, the Pennsylvanias, the Ohios and other areas that we are so fond of talking about as all of the veterans are leaving, while we have a shrinking veterans population, we have an increasing veterans population of veterans over the age of 65 years of age, and many of our facilities in our areas are suffering some of the same long lines and same stress that you are experiencing.

Statistics indicate that the veteran population over 65 will triple over the next 10-year time frame, and that is because the World War II is moving to that age, and the average age of those veterans is moving to the point where they will need increased services from the Veterans' Administration.

So I hope that we can do two things. One is address your need in areas of inmigration for new structures, new clinics, new hospitals, new care facilities for the aging, but that we will also recognize the need for rehabilitation construction and renewal of existing facilities throughout the country.

One of the problems I have with some of the rhetoric of the last year and a half about budget cuts is that we sound the signal that the Government ought to get off people's back and out of their pocketbooks, and yet I think there are some legitimate areas where targeted expenditures on behalf of certain populations of people or on behalf of certain needs are critical, and in times of limited budgets we have to be flexible enough to address your needs in Florida, as well as the rehabilitation needs of other parts of the Nation.

So I join with you in your concern and your problem, and I hope this committee can assist you in accelerating the speed with which some of those facilities are created, and I just hope that you will help us to respond to some of the needs of the increasing population of veterans in our areas, as well, of aged veterans who need special services. Thank you very much.

Mr. MOTTL. Thank you very much, Mr. Edgar. Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman, and I might just point out before my colleague from Pennsylvania leaves, we certainly do, as the delegation, and I as a member of this committee, recognize the needs of veterans in this Nation, and certainly we, as a delegation, do not in any way wish to lessen our commitment nationwide.

Some of the statistics you pointed out, a tripling nationwide of veterans over the age of 65, is correct. In Florida it is sixfold. Every figure that comes out nationwide, doctor-patient ratio, the disparity in Florida is growing because of the large numbers coming. So we obviously, as a delegation, and I as an individual, will do everything we can to make sure that we have adequate and proper funding for veterans nationwide, but we do want to narrow that range that we see growing, and that has been in all the years. I am going to submit information for the record on this, but every figure that has come along——

Mr. MOTTL. Without objection, it will be inserted into the record at this point.

[The prepared statement of the Honorable Daniel A. Mica appears on page 35.]

Mr. MICA. At this point I would like to recognize my colleague, freshman Congressman Bill McCollum, who has expressed a great interest in Florida's veterans, and we have worked very well together.

Mr. MCCOLLUM. Thank you very much, Dan.

Mr. MOTTL. Bill, welcome this morning. It is a pleasure having you here.

STATEMENT OF HON. BILL McCOLLUM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. MCCOLLUM. Thank you, Mr. Chairman.

Mr. MOTTL. We look forward to your testimony.

Mr. MCCOLLUM. I have a statement, as others, to submit for the record, but I would just like to make a few brief comments, Mr. Chairman.

Mr. MOTTL. Without objection, it will be inserted into the record.

Mr. MCCOLLUM. Thank you.

[The prepared statement of Hon. Bill McCollum appears on page 111.]

Mr. MCCOLLUM. I happen to have represented for the last 18 months, had the privilege of representing, the largest district in population in the United States, over 880,000, according to the census. I will not have that privilege after redistricting in the next election, obviously, but I do now, and in the process, the two biggest items on the veterans' concerns that have come to my attention are interesting because of the fact that the big population is there, and at the same time most veterans in my district are within a 50-mile radius of some veterans' facility, hospital or otherwise, and yet they still are complaining, not of the quality of the service that they receive at those facilities, which is admirably higher than one might have expected, or as I have heard may be, in the case of some of the other facilities that some of my colleagues have addressed this morning. But they have complained to me consistently of the fact that unless they are service connected in disability, they are not able in many cases to get into the facilities because of overcrowdedness, and as equally important to them is the fact that due to the high growth of population and tremendous congestion in part of my district, in particular, and the lack of transportation systems which are really lagging far behind, and they are not a problem of this subcommittee, and really are more a State problem than a Federal one, but nonetheless, because of the transportation-lagging factor and the high congestion, they are in many cases not able to easily or accessibly get to the facilities that are available.

I have discussed with the Veterans' Administration on more than one occasion the possibility of developing some innovative ideas to allow for traveling outpatient clinics throughout the areas where this type of congestion exists, even when there is proximity to hospitals within the so-called 50-mile radius. So far as I know that has met with relatively deaf ears, but quite frankly, in my judgment, and in what little studies that have been done that have been precipitated to this point, it may very well be cost effective to do that, especially with the cooperation of local hospital facilities that are either private or public in nature, who have indicated a willingness to cooperate, and I would submit to the subcommittee that this is an extremely important aspect to consider as the population multiplies and the congestion increases in the area of Florida.

I am sure that it is not unique to my district. I am sure it is a problem that is being encountered by my colleagues, and I would urge some innovative and creative thinking to save costs for the veterans' budget and at the same time to provide this type of outpatient service, as well as to support the strengthening of the hospital system so that we do not have those turned away from hospital care who do not have a disability, service connected, and of course, Florida has many, many who are eligible, other than those who are service connected.

I thank you for the opportunity to present those views.

Mr. MOTTL. Bill, thank you for the outstanding job you have done here this morning. I certainly appreciate your testimony.

Mr. Mica.

Mr. MICA. Mr. Chairman, I would like to present Congressman Earl Hutto from Florida's First Congressional District, and he is a

member of the Armed Services Committee. So a great deal of what we do does have a great deal of concern to Congressman Hutto because of his overall jurisdiction for the defense of this Nation.

Mr. MOTTL. Earl, we look forward to your testimony this morning. You have been an outstanding member of the House of Representatives, and you may proceed as you see fit.

STATEMENT OF HON. EARL HUTTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. HUTTO. Thank you very much, Mr. Chairman. We will certainly miss you as a teammate on that Democratic baseball team. I still remember quite well our toils together under our manager over here when we won in 1979 and 1980, I believe it was, and that is the year that I got myself——

Mr. MOTTL. That you incurred that unfortunate injury.

Mr. HUTTO. It is an honor to be here before your committee and to join my colleagues from Florida in expressing the needs of the veteran population of our State.

You have heard how it is increasing tremendously all of the time, so we are grateful to you for hearing the Florida story, and I am grateful to my colleague, Dan Mica, for his work on this committee.

In my own district, there are about 97,000 veterans in the northwest Florida area, and this represents almost one out of every five citizens in my district, and coupled with the large veterans population is an estimated 30,000 active military personnel. So from these numbers alone you can see the need for medical facilities in our area.

I want to thank my colleague from the adjoining district, Congressman Don Fuqua, for his work in helping us, and Senator Chiles, over on the Senate side, who has worked on this for a long time, too. We are going to get, for activation in 1984, a VA clinic in northwest Florida, and the VA has said that it should be located in the Pensacola area because of the large population there, and the veteran population, but this is something that we have been needing for a long, long time.

Our situation is considerably different from that described by Congressman McCollum because we do not have VA facilities within a 50-mile radius. In fact, our veterans have to go to such places as Tuskegee, Ala., and Montgomery, and to Biloxi, Miss., and out of State into other facilities in order to receive proper medical care. So we are grateful to you, and we want to ask your continued support as we try to attend to the medical needs of our veterans in northwest Florida.

I would like to ask that the balance of my statement be submitted for the record.

Mr. MOTTL. Without objection, it will be so included.

[The prepared statement of Hon. Earl Hutto appears on page 112].

Mr. MOTTL. We want to thank you for your great job this morning.

Mr. HUTTO. Thank you very much.

Mr. MOTTL. You have done a fine job for the subcommittee.

Mr. Mica.

Mr. MICA. At this time I am very proud to introduce one of Florida's full committee chairmen, the only full committee chairman, Congressman Don Fuqua.

Congressman Fuqua.

Mr. MOTTL. Don, we want to welcome you here this morning. You know, we have had the pleasure of working with your Science and Technology Committee for Lewis Research in Cleveland. You have done a great job as chairman of that full committee.

I know you have great concern for America's veterans, as well as the veterans in Florida. It is a pleasure to have you here this morning.

STATEMENT OF HON. DON FUQUA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. FUQUA. Thank you very much, Mr. Chairman, and let me thank my colleague, Dan Mica, for his leadership in getting this hearing scheduled.

Our Committee on Science and Technology has worked very closely with the Aging Committee and, the Veterans' Affairs Committee in trying to facilitate technology transfer that can help, particularly in the medical field, but also in handicap areas, and we are very proud of the work that we have been able to do in trying to develop that technology, and, of course, the veterans are very important to me in my district, the second district in northern Florida.

I have had the pleasure of representing two VA hospitals in my district—Gainesville and Lake City. I think they are two facilities that we can be very, very proud of.

I do not have a prepared statement. I am just going to summarize very briefly some remarks. I do not think I can add a great deal to what has already been said, but we do have facilities in northern Florida that can be expanded to take care of some of the increased pressure for services that we have, particularly in the Lake City area.

Also, I might point out, as Congressman Hutto mentioned, we are trying to get a VA clinic located in northern Florida. The Veterans' Administration chose Pensacola. That still leaves a big void area where many people have got to travel over 150 miles in order to receive outpatient treatment. This is not hospitalization, but to even get to a hospital or a clinic where they can receive treatment; and I think we should explore the possibility of an additional clinic in the Tallahassee, Quincy, Marianna, Panama City area so that it can adequately take care of the needs of the veterans in those areas, particularly in an outpatient fashion.

The tremendous growth that we are having is mainly in the southern part of the State, but there is also a great deal of veteran growth in the northern part, and because of the vast-expanse panhandle of Florida that Congressman Hutto and I represent, it does leave long distances for veterans to travel. As has already been pointed out, also, many of these veterans of World War II are approaching the age of 60, and they have increasing needs, particularly those service-connected disabilities, those that have shrapnel

wounds, etc., are beginning to have certain discomforts and other medical adversities as a result of those wounds, and we need to provide some type of easily accessible care for our veterans.

I thank you, again, Mr. Chairman, for permitting me the opportunity to be here today, and thank you very much for holding this hearing.

Mr. MOTTL. Don, thank you for your great contribution. You did a great job, and we certainly appreciate all of the effort that you have made on behalf of your full committee, and for veterans, and for the medical needs for all Americans. Thank you very much for being here this morning.

Mr. FUQUA. Thank you.

Mr. MOTTL. Mr. Mica?

Mr. MICA. I at this time would like to introduce my colleague, Congressman Bill Chappell. His name has been synonymous with strong defense and concern for veterans of our State for many years.

Congressman Chappell.

Mr. MOTTL. Mr. Chappell, before you begin, we want to welcome you this morning. You are not only a great Congressman, but you are a great catcher and a great manager.

STATEMENT OF HON. BILL CHAPPELL, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. CHAPPELL. Mr. Chairman, I appreciate that very much, and I want to take this opportunity to thank Dan Mica for the very fine work that he has been doing here and for helping arrange this opportunity for this delegation.

I especially want to thank you, Mr. Chairman, and this very fine committee for what you have done for our veterans and the help you have given us in Florida.

I want to say, too, that I do not believe anyone is going to miss Ron Mottl in the Congress more than I because you have been a great friend, and you have been such an outstanding athlete pitcher for us, and I guess a lot of people do not realize the fact that you pitched the ball game the other night, and I do not think you walked the first man. You did hit one, but you did that even without harm.

Mr. MOTTL. I did it without pain, anyway.

Mr. CHAPPELL. You did that without harm, and you hit well and you pitched well and you tagged well. You did everything. I have never seen a pitcher play a more perfect game, and I want to tell you I think you do equally well as chairman of this committee.

Mr. MOTTL. The compliments will get you everywhere. That is why we want to help Florida here.

Mr. CHAPPELL. We are going to miss you, Ron, and it will do no good for me to go back over the statistics which have been given here, the fact that we have about 5,000 veterans coming into Florida a month. That alone points up some of the problems which we have.

I would like to specifically mention though the outpatient clinic which we have been trying to get in Daytona Beach. For 3 years the Congress has directed the Veterans' Administration to go for-

ward with that clinic out of available funds, and they still refuse to do it. I hope that they will soon see the necessity and the good judgment in doing that, as well as taking care of the clinic out in northwest Florida.

So, Mr. Chairman, I have a statement I would like to put in the record.

Mr. MOTTL. Without objection it will be included.

[The prepared statement of Hon. Bill Chappell, Jr., appears on page 112.]

Mr. CHAPPELL. I will not take further time other than to join with my colleagues in the concern which we have in Florida with the problems and join them in being proud of what we have been able to do in Florida for those veterans, and to express our appreciation again to you and this committee for the very fine concern you have for veterans.

Mr. MOTTL. Thank you for the splendid job you did here this morning on behalf of the veterans of Florida.

Mr. Mica.

Mr. MICA. Thank you, Bill.

At this time I would also like to introduce another Bill, Bill Nelson from Florida, and Bill is on the Budget Committee, and there is not a committee in the Congress where the veterans need a little compassion and concern more than the Budget Committee.

Bill, welcome and we appreciate your being here.

Mr. NELSON. By the way, in the final work product that came out of function 700 for veteran spending turned out very well for the veterans.

Mr. MOTTL. Thanks to your efforts, Bill. We welcome you here this morning and we look forward to your testimony.

STATEMENT OF HON. BILL NELSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. NELSON. Mr. Chairman, again I would add my accolades to your distinguished career here in this Congress, and we are going to miss you very much as a colleague and as a personal friend.

I think we have a unique situation in Florida. We have a land that is very attractive for people to come to live, particularly during the twilight years. We have a land that is blessed with an environment that is more conducive to those who have suffered during the course of protection of their country, such as our veterans, our disabled veterans.

Thus, the 5,000 veterans a month now coming into Florida is an understandable statistic. When you combine the geography of Florida with its increased veterans population coming, you see that you have an additional problem coming because there is no one major urban center around which everything else collects, but rather a proliferation of urban centers and veterans populations throughout the State.

Now, we have the medical center and we have the veterans hospitals, our main ones are in Gainesville in north central Florida, in Tampa on the west coast, in St. Petersburg on the west coast, and then down in Miami. Yet increasingly there is a concentrated veterans population in Palm Beach County, the district Mr. Mica rep-

resents; in east central Florida—the Orlando, Brevard, Volusia County area, and for the veterans needing medical attention, they have to drive, many times, over 150 or 200 miles to get that medical attention if it cannot be handled in an outpatient clinic. We do have an outpatient clinic in Orlando, but many times that cannot handle the needs of the disabled veterans.

I want to thank publicly the Veterans' Administration. Three years ago, recognizing that the Orlando outpatient clinic was one of the most crowded in the entire Nation, they expanded almost double again but with 5,000 veterans coming into Florida each month, soon its facilities are going to be woefully overtaxed as to the services that we want to provide for our veterans. So, having said all of that, I want to commend this committee for insisting from the Veterans' Administration for this indepth study, which I understand is going to be reported in the near future from the VA, stating what are the additional medical facilities, including the possibility of another VA hospital in Florida.

Now, in the past the VA has had a standard that they would not locate a hospital unless it was at the same location of a medical school. I would urge this committee and the Veterans' Administration to see that that standard should not apply to Florida in the future. They already have VA hospitals near existing medical schools. The population of veterans is concentrating in areas other than where there is the location of a medical school, specifically in my region of east central Florida and in the region down around West Palm Beach.

So I would urge this committee and the VA to locate another hospital, VA hospital, in Florida to try to adequately take care of this exploding veterans population in Florida. Short of that, then I would urge them to locate outpatient clinics in an area where it will not put the hardship upon the veterans population in order to travel to an outpatient clinic or to a hospital.

That is my statement.

Mr. MOTTL. Thank you very much, Mr. Nelson, for your outstanding statement.

Mr. Mica, would you like to recap then for the committee?

Mr. MICA. If I may take one moment and sum up, and then at the Chair's leisure, we will recess for a moment.

First, again I would like to join with all the Florida delegation in thanking you for holding this hearing and for recognizing that Florida does have a special problem.

We, indeed, do. The statistics point this out.

Second, I would like to mention this study. We in the committee authorized that study, and it is ongoing. It will be completed, I am told, in about 3 months. There is no doubt in my mind that that study, along with this hearing, will indicate that Florida needs not only a new hospital, but new outpatient clinics, a whole range of services and increased facilities in areas where we already have existing facilities.

I think that study without a doubt will indicate far beyond what we have been able to indicate the needs in Florida, and I think one of the easiest decisions to be made is whether or not we need a new hospital. I believe we will, and as my colleague has said, and as I understand—and I would like to be corrected if I am not correct on

this point—it can be located a distance away from an existing medical school.

Mr. MOTTL. Mr. Mica, may I just say in conclusion, because you are going to chair the meeting when we come back to hear the rest of the witnesses, that after listening to your delegation and yourself, I am convinced that Florida needs another hospital and needs other outpatient facilities.

This subcommittee will work toward that end with your help, and we want to achieve that. I am sure this study will show this, as well as the testimony this morning, and we will look forward to the other witnesses this morning that you will be chairing the rest of the committee.

But I want to commend you and the entire delegation for the outstanding job that you have done here this morning.

Mr. MICA. Thank you, Mr. Chairman, and your comment with regard to the need, I am sure, will go a great deal in assisting us in Florida, and without objection I would like to submit a statement for the record with regard to our needs, a copy of my report to the full committee on the needs of Florida when I recently toured the State of Florida,[1] factsheets on the medical centers in Bay Pines, Tampa, Gainesville, and Miami, and also visitation reportation on each of those facilities for the record.[2]

Mr. MOTTL. Without objection they will all be included. I might suggest that Tallahassee, your State legislature might want to add another medical school in the area where we are going to put the new hospital. That might also work out very well for Florida's needs.

Mr. MICA. Thank you, Mr. Chairman.

Mr. MOTTL. We will recess for about 10 minutes for the vote, and then we will come back and Mr. Mica will chair the rest of the subcommittee meeting.

[Recess.]

Mr. MICA (acting chairman). The committee will come to order.

Before we proceed, I would like to say that I have had requests from all of the members of the Florida delegation to be associated with this hearing and their comments associated with the needs of Florida veterans and indicate again for those who have not heard it that the record will remain open for 5 days for any additional statements that they may wish to have inserted into the record.[1]

Also, I would like to point out that the Governor of Florida has prepared and sent a statement and asked that it be submitted in the record and to express his concern and interest over Florida's growing veterans needs.

One other point before we proceed, if the Chair may take the liberty of asking counsel. The question has come up several times with regard to the need to have any new hospital built anywhere in the Nation, let alone Florida. Must a new hospital be next to a medical school or a college of medicine?

Mr. CASTEEL. Mr. Chairman, I could answer this in this way. This is not a matter of law. This is a matter of VA internal policy of

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[1] See p. 111.

[2] See pp. 36–95.

locating hospitals as close as possible to medical schools for the purpose of affiliating to try to improve the quality of care.

The answer to your question specifically is "No".

Mr. MICA. Thank you. I appreciate that, and with that we will move into our next panel headed by Dr. Earl Brown, the associate deputy chief medical director of the Veterans' Administration.

Dr. Brown, we are very pleased to have you and your distinguished panel here today, and if you care to do so, you may introduce any members of your panel you would like.

STATEMENT OF A PANEL CONSISTING OF D. EARL BROWN, M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; TOM DOHERTY, DIRECTOR, VA MEDICAL CENTER, MIAMI, FLA. AND SAM FORESMAN, CHIEF, MEDICAL ADMINISTRATION SERVICE, VA MEDICAL CENTER, BAYPINES, FLA.; DONALD THOMPSON, REGIONAL DIRECTOR, SOUTHEAST REGION; MARJORIE QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION, RALPH IBSON, OFFICE OF GENERAL COUNSEL: FRANK MORRONE, DIRECTOR OF HEALTH SYSTEMS INFORMATION SERVICE; ROBERT SCHULTZ, ASSISTANT DEPUTY ADMINISTRATOR FOR REPORTS AND STATISTICS

Dr. BROWN. Thank you, Mr. Chairman.

With me today are Mr. Donald Thompson on my right, the regional director of the southeast region; Ms. Marjorie Quandt, the assistant chief medical director for administration, to my far right; on my immediate left is Mr. Ralph Ibson from our General Counsel's Office; to my far left is Mr. Frank Morrone, the director of health systems information service; behind me, Mr. Sam Foresman, the Chief MAS of Bay Pines Clinic; and Mr. Robert Schultz, the assistant deputy administrator for reports and statistics.

Mr. Chairman, we are very pleased to be here today to provide an overview and discuss the veterans health care delivery system in medical district 12, which is comprised primarily of the State of Florida.

I would like first to discuss and compare this medical district's delivery of health care with the rest of the nation. Over the past 7 years, the Veterans' Administration has experienced 122 percent increase in its medical care budget and a 17 percent increase in employment. During this same period, the Florida facilites have received a budget increase of 148 percent and an employment increase of 26 percent. In fiscal year 1981 medical district 12 had an estimate veteran population of 1.4 million, which is approximately 5 percent of the nation's total veteran population.

The most reliable basis for future planning will, of course, be the 1980 census data which is not yet available. We have until recently based our planning on 1990 veteran population projections, which we now recognize to have been overstated because of a technical flaw in the projection methodology.

Therefore, we are developing interim population assumptions utilizing both agency and consultant resources. These revised figures will be used for planning purposes until the 1980 census data is available.

Looking at the current usage, we note that in fiscal year 1981, the rate of applications for care in Florida was 18 percent above national average. This factor further amplifies the impact of the growing population.

The growing demands for service, coupled with the priority system as established by Congress, have resulted in a higher percentage of service-connected veterans being treated by the Florida facilities. As an example, in fiscal year 1981 61 percent of all outpatients treated in Florida were service connected, as compared to a system-wide average of 47 percent.

However, with fewer medical, surgical and intermediate care operating beds per 1,000 veterans, our Florida facilities treated more patients per 1,000 than the system as a whole in fiscal year 1981.

The above information clearly indicates that we are experiencing a constant growth in the veteran population in the State of Florida, which includes a high percentage of service connected and older veterans. The statistics also show that the resources have been allotted to the State of Florida in greater proportion than to the system as a whole, and that VA health care facilities in Florida are still providing more care per 1,000 veterans than the system as a whole.

However, we recognize we are not dealing with all of the demands for care in Florida. That being the case, in an environment of constrained resources, it becomes necessary to apply the priority system set by Congress to determine which veterans are going to be provided care within a reasonable time frame.

The growing demand for care was recognized during the fiscal year 1983 budget hearings held by the regional director in March of 1982, and $1 million and 13,500 outpatient staff visits were redirected from other VA facilities to Miami. Following those budget hearings, 20,000 out-patient visits and $1 million were also added to Tampa's budget for fiscal year 1983.

Since that time we have also finalized plans to provide 161 additional FTE and more than $5 million in construction with the completion of the replacement facility at the VA Medical Center in Bay Pines.

My formal statement lists other resource adjustments and details of significant construction plans that will increase our capacity to meet health care demands in Florida.

Mr. Chairman, our future planning is structured to fully consider the needs of veterans in the State of Florida. Over a year ago the Veterans' Administration established a grassroots planning process called the medical district initiated program planning, MEDIPP. This process involves management and program officials at the facility and district level who have been given the responsibility to develop comprehensive program plans.

Medical district 12 is fully involved in addressing this responsibility, and we are also conducting a 30-year study in health care requirements of Florida veterans as mandated by Senate Appropriations Committee report language accompanying our fiscal year 1982 appropriations. This study will include the assessment of the need for hospital, out-patient and nursing home and domiciliary care over the 10-, 20-, and 30-year planning horizons.

Mr. MICA. If I may interrupt at this point, I am going to have to explain what is about to happen here. There is a major vote going on in another committee that I serve on on nuclear arms reduction and the SALT talks and the freeze. Rather than to have the distinguished panel wait for 5 or 10 minutes while I try to race for the vote and make it back, and the vote may be delayed, I am going to at this time recess the hearings until 11 o'clock. It should all be over by then, and hopefully no further interruptions will occur, but this is unavoidable, and we do apologize.

I would say that there are facilities here in this building if you would like to get refreshments, and the staff can direct you, and maybe this will make it easier for both of us.

The subcommittee will stand in recess until 1 o'clock.

[Recess.]

Mr. MICA. The subcommittee will come to order.

Let me just give you a progress report. The vote was delayed for another 15 or 20 minutes. So I am probably going to have to go back, but I do ask your indulgence.

As I explained, this is probably a key vote on the Foreign Affairs Committee on strategic arms limitation, and I do not want to miss it if at all possible.

Dr. Brown, if you will continue, and again, thank you for your patience.

Dr. BROWN. Thank you, Mr. Chairman. I will just summarize.

We are experiencing a constant rate of growth of the veteran population in the State of Florida which includes a high percentage of service connected and older veterans. We have in the past and will continue to take steps to alleviate the effect this growth is having on our health care delivery system in Florida.

The long-range solutions will include analysis of the distribution of our limited resources to various regions of the country so that there is equity of access to care for veterans in different geographic sections of the country.

We believe that through the concerted efforts which are presently underway we will attain an appropriate and equitable distribution of workloads and resources.

That concludes my remarks, Mr. Chairman, but I would like to introduce Mr. Tom Doherty, the Director of the VA Medical Center in Miami, Florida, who is also with me. He has a statement, and we will submit that for the record in order to save time.[1]

Mr. MICA. Thank you. Without objection, your entire statement will be submitted in the record, and we do again thank you for your patience.

[The prepared statement of Dr. D. Earl Brown, Jr., appears on page 114.]

Mr. MICA. Let me indicate this also. As acting chairman of the committee at this point and as a member of the full committee, without objection I am going to ask that you stand ready to respond to any written questions on your testimony as we have a chance to review it.

Dr. BROWN. We are ready for your questions, sir.

Mr. MICA. Thank you, Dr. Brown.

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[1] See p. 119.

It is also my understanding that we have Mr. Doherty's statement for the record, and we thank the distinguished panel for being with us today.

At this time we will call the next panel forward. I might ask the panel what is your time frame. If I have to leave and come back, would you have an opportunity to again take the witness table for some brief questions?

Dr. BROWN. We will be here, sir.

Mr. MICA. All right. Thank you.

We would like to call as our next witnesses a panel that will include Mr. Gordon Mansfield, Mr. Donald Schwab, and Mr. Charles Joeckel.

Gentlemen, if you would please take the witness table.

While you are doing that, let me say again that it appears that this vote is about to take place. I would ask that each of you summarize for the record your statement, and I probably will have to leave in the next minute or two, and then we will come back and pick up as soon as possible after the vote.

You may proceed in whatever order you desire. Mr. Mansfield, you are first on your list if you would like to proceed first, or if you have agreed among you to have one of the others start first, that is fine with the Chair.

STATEMENTS OF A PANEL CONSISTING OF GORDON H. MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND CHARLES E. JOECKEL, JR., DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. MANSFIELD. Thank you, Mr. Chairman. My name is Gordon H. Mansfield, associate legislative director for Paralyzed Veterans of America. I would request that my full statement be submitted for the record.

Mr. MICA. Without objection.

[The prepared statement of Gordon H. Mansfield appears on page 120.]

Mr. MANSFIELD. I believe the facts of Florida's unique position with regard to the population increase and the concomitant increase of veterans have been aptly pointed out previously this morning. I think it is obvious that a 43.4 increase in total population in 10 years, with 25,000 persons a month—of whom 5,000 are veterans—moving to the State of Florida each year, obviously indicates a need for more VA resources now and in the future.

The existing veterans population of 1,369,000 in Florida makes that State the seventh largest in terms of total veterans population among the States, but I think it is also important to realize that Florida ranks third in the percentage of veterans to the total State population.

Another unique factor which needs to be pointed out and understood in planning for provision of VA services now and in the future is the distribution of this increase in population statewide. I refer you to page 3 of PVA's prepared testimony, which shows the

increase in population by congressional district throughout the State during the period 1970 to 1980.

I might point out that in these areas the population during that period increased from a low of 3.6 percent to a high of 93.9 percent.

Another factor to consider is the fact that the unique geography of the State with a 400 mile length from Jacksonville to Miami and then another 400 miles across the panhandle from Pensacola to Jacksonville are also features that have to be addressed. It has been pointed out that the need for the veteran to travel large distances to reach VA facilities presents a problem.

Another point which PVA feels must be made and which is important is the seasonal influx of residents during the winter season and the fact that this aggravates the situation in Florida because oftentimes it requires that these individuals who have a higher priority of care, who come to the State for extended periods, but are only seasonal residents, take up resources that ordinarily in other States would be allocated to the normal residents.

PVA does not argue that there ought to be uniform classifications for the priority of VA services, but we do point out that in Florida there is a special situation because this uniform classification for priority health care should assume that there is uniform ability to deliver health care. This does not exist in Florida, and the situation is exacerbated during the period when these seasonal residents are in the State.

Realizing the constraints of time, I would specifically like to direct myself to some problems that the SCI, spinal cord injury, patient has here in Florida. Specifically with regard to the Tampa VA medical facility, which is operating at 100 percent of capacity on a daily basis, every monthly report that comes out shows a 95 to 98 percent occupancy rate and a 70 to 80 percent turnover rate.

Also, this facility is providing care almost exclusively to service connected catastrophically disabled veterans. PVA hopes that when the situation in Florida is considered that the VA will place the highest priority on the proposed expansion of this facility from 42 beds to 100 beds.

One important fact which must be considered and has already been addressed here this morning for the present and future provision of services in Florida is that not only is there a need for the physical resources of beds and hospitals and clinics, but there has to be adequate staffing to back up and provide for adequate health care for the veterans in the State of Florida.

We have a situation once again in the Tampa SCI unit where for a number of years they have not been able to maintain the level of nursing care personnel, specifically RN's, as required under the FTE's that are allocated. This problem has been further complicated by the fact that the number of RN's has been reduced over a period of the last few years from 14 to approximately 9, and the difference has been made up by using LPN's or LVN's. This means that the SCI veteran in the Tampa Bay SCI Center right now is not necessarily getting the best possible health care that the VA system can deliver because there is a decrease in the professional abilities and in their ability to deliver health care to these veterans. PVA has made recommendations in its prepared testimony which include one thing I would like to emphasize, and that is the

need for special satellite clinics which would be located outside the 50 mile radius. Because of the unique geography of the State, which requires the travel of long distances and the fact that for the SCI or catastrophically disabled veteran travel arrangements are often a problem, this situation again, as pointed out in the Tampa unit, where when emergency admissions are made to a unit that is already operating at almost 100 percent, if not 100 percent, capacity, that regularly scheduled treatment which is definitely required for the SCI patient must be canceled for some people who have appointments. This situation will be especially aggravated if you get somebody that is coming from way up in the panhandle or over toward Jacksonville. PVA believes that the use of specially trained SCI personnel visiting newly established satellite clinics on a regularly scheduled basis might be able to alleviate some of these problems.

As a final point, Mr. Chairman, I would like to point out that I think the veterans of Florida need some assurance that the VA is going to be able to and is going to desire to provide adequate health care to these veterans. We have all been aware here in Washington of the recent publicity given to Administrator Nimmo's positions on various issues with regard to the VA. Questions about what degree of care does the veteran deserve, questions about how much construction should take place, or do we stop it now and do we stop it while studies are being made raise great concerns in the veteran population, and especially in a State like Florida where you have such a large concentration and they make up such a large percentage of the population.

These individuals right now have to look to this committee and to this Congress to assure them that what was promised to them will be delivered. How can this committee think about planning for future care in Florida, including future facilities or future construction, when previously planned facilities nationwide, which have been considered for a number of years by this committee and the full committee and the committees that provide the allocations of dollars have just been stopped cold in their tracks while so-called new studies are made to determine whether they should be there.

Thank you, Mr. Chairman.

Mr. MICA. Thank you, Mr. Mansfield. It is with a great deal of regret that I am going to have to do this, and I know you have waited patiently, but maybe if we could do this. I have about 1 minute to make it over there for the vote. If you all could split that minute, and if there is a specific point you could quickly make then we are going to have to recess the hearings at this time.

There are a few folks that have testified that I have requested to come by my office later today, but we do apologize. Events have overtaken us at this point in time, and I am asking that all statements be submitted in their entirety in the record.

Mr. Joeckel, do you have a brief statement?

STATEMENT OF CHARLES E. JOECKEL, JR., DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. JOECKEL. Well, I perhaps could sum up my testimony Mr. Chairman, by saying that after listening to the gentlemen who tes-

tified this morning from the delegation of Florida, you have been bombarded with statistics, and there is no point in going further with that. But, I would say that I was pleased to hear their commitment to veterans programs in terms of the budget.

When we compare last year's budget, with the budget adopted this year, we find that in budget authority the VA was cut by about $300 million. That is $300 million less than we had last year.

There has to be a commitment on the part of the Congress to put the dollars where they are necessary. Certainly they are needed in Florida, but we have a problem in the VA health care system nationwide, and we hope that through this hearing and others we can address this need.

And let me add this, too, that the DAV in considering your bill, H.R. 6401, believes that the VA has for some time used these requirements. We see the enactment of your bill as nothing more than putting into statute and formalizing just what the VA is doing now. However, it would be easier for us to justify those VA projects if these requirements were already in statute.

Thank you.

[The prepared statement of Mr. Joeckel appears on p. 126.]

Mr. MICA. Thank you for your comments.

Mr. Schwab.

STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. SCHWAB. Well, Mr. Chairman, I cannot say what I think needs to be said in half a minute, and I would just as soon continue my testimony when you reconvene the hearing.

Mr. MICA. I regret to say this, but because of other events that are now coming into being, we will not be able to reconvene in the next few minutes. We are going to have to adjourn the hearing, but if you would submit your statement in the record, we would certainly appreciate it.

I must apologize for this. In several of the other committees that are taking the time of our members, they are bringing forth issues they are trying to wrap up before we as a Congress leave here tonight or tomorrow for 2 weeks, and most of the items that have called other members away were not scheduled even as late as yesterday.

So events are beyond my control. The votes that we are arguing about today were guaranteed to have been taken by yesterday, but it has not been taken yet. So if you could——

Mr. SCHWAB. Well, let me say this, Mr. Chairman.

Veterans are being denied care in Florida. The director of the out-patient clinic at Fort Myers said at a hearing before the Senate earlier this month, the inability to provide VA care to service-connected veterans, the highest priority group, in the foreseeable future is a possibility.

Now, we believe that the Federal budget is all out of kilter, and I think that this House committee print, No. 74, dated March 15, laid this out quite well, wherein it indicated that the VA's portion of the budget in the last 33 years has increased only threefold, and

during this same period, the Human Resources' budgets have multiplied several hundredfold.

In this same period we add 13.1 million veterans to the veteran population. Unless the Veterans' Administration gets a larger proportion of the Federal budget, we are going to see this hospital and medical care system go down the chute, and there is no question about it.

Ten years ago the VA portion of the budget was 4.9 percent. Senate Concurrent Resolution No. 92, passed by both bodies now, it is 3.1 percent, and we have 30 million veterans. There are no shortcuts; there are no alternative methods. The VA budget just has to be a larger proportion of the Federal budget.

We owe more to our veterans than we do to the social welfare recipients who may have never done anything for this Nation and may even have acted against its best interests in the past, and I thank you.

Mr. MICA. Thank you, Mr. Schwab.

I might say that that is one of the most salient points that have been brought up today. The veterans population and its needs are expanding, and the percentage of the budget is going down. So nationwide that is a major part of our problem, and of course, any problem in the Nation is exaggerated in Florida where we have this rapid growth.

But that comment is very, very appropriate. We appreciate that.

[The prepared statement of Donald H. Schwab appears on page 128.]

Mr. MICA. I regret that we do not have more time, but we will put all comments in the record, and we will be in touch with you with regard to specific questions.

Thank you very much. The meeting stands adjourned.

[Whereupon, at 11:25 a.m., the subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Lawton Chiles, a U.S. Senator From the State of Florida

I appreciate having the opportunity to be here today. I want to commend Congressman Mica for pushing for this hearing and to thank this subcommittee for scheduling it. It is my understanding you are to hear from the people who are staffing the veterans' medical facilities in Florida and there is no doubt they can paint for you the real picture of what the situation is in my State. In short, we are bursting at the seams. Either we are going to have to do something to solve the problem or countless veterans are going to be turned away without receiving the treatment and care to which they are entitled.

Everytime I go home I hear from veterans who relay stories to me about seeking care at a veteran's facility. Often, these are new veterans in our State, veterans who have moved from up north to enjoy our Florida sunshine. We welcome them, but they are accustomed to receiving the necessary medical attention from the VA, and soon they find out they just can't be accommodated. I hear this over and over again from non-service connected veterans. From service-connected veterans I hear about long waits created by staff cutbacks and increased demands. I think this Committee needs to get a clear picture of what our situation is in Florida in terms of rising veteran population and what this means in terms of the VA being able to effectively serve its constituency.

Let me share a few statistics with you:

Florida's veterans population now exceeds 1.3 million and is expected to reach 2 million by 1990.

Florida has the fastest growing veteran population in the nation—5,000 veterans move to Florida each month.

National studies show that approximately one out of every 5 veterans seek medical care from the VA. Since our veteran population is older than most states, I'd bet Florida's ratio is even smaller than one out of five.

Generally, the average age of veterans in Florida is higher than it is anywhere else in the country. Approximately 15 percent of Florida's population are veterans over 65 years of age. This age group obviously requires much greater support in terms of resources. They require more frequent visits, have multiple medical problems, and have a greater impact on pharmacy services.

What all these statistics and facts add up to is the plain fact that Florida's ballooning veteran population has strained Florida's VA medical facilities to the breaking point. Now, we all know that in this era of budget cutting and belt tightening, we can't realistically expect to see huge increases in VA medical care funding. I'll tell you, we are doing the best we can right now just to hold on to what we've already got.

What we can do, however, and what I plan to work for, is to make sure that the VA health care funds that are appropriated by Congress each year are allocated in a way that reflects the changing veterans population.

In other words, let's make sure Florida receives its fair share of the pie. Florida should get an amount of money from the VA budget that reflects the number of veterans in the state. Now how do we go about doing this? I think we need to put on the books a process or a system that makes sure that when a state like Florida sees a boom in their veterans population, that the money allocated to that state will reflect that change in population.

This isn't a problem that just sneaked up on us. I've been in touch with the VA on this matter for several years now, and they keep promising that they are working on a system that will shift resources to follow demand. But the clock keeps ticking, and nothing has been done. And I don't see any signs that indicate that the situation in Florida, particularly in Broward and Dade counties, is going to get any less crowded.

I think we need action now to address our state's exploding population of veterans and the accompanying increase in demand for VA medical services.

To try and solve this problem, Congressman Mica and I have introduced legislation which will require the VA to compile important up-to-date information on where veterans live, where health care demands are the heaviest, and most importantly, information that tells us how well the existing staff, facilities, and VA services are meeting the needs of eligible veterans. The bill will require the VA administrator to look at this information and to operate and establish VA medical facilities on the basis of this information.

The areas where the large veteran populations live will start getting the funds and facilities to meet the needs of those veterans living there. This kind of system, which can't be run without the decision-makers having current date on veterans, is simply the fairest and most reasonable way to go about providing for the health care needs of this country's veterans.

This bill goes a long way toward reforming the VA system of allocation. If we document where the veterans live and what health care needs they have, and then we require the administrator to apportion funds based on all of that information, then I think we are taking a very positive step towards making the VA health care system more responsive to the needs of veterans.

I hope this information received by the subcommittee today will illustrate some of the problems I have referred to. In turn, I hope this subcommittee will begin addressing the need for an equitable distribution of veterans' funds based on where veterans live and what their health care needs are.

PREPARED STATEMENT OF HON. C. W. BILL YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, thank you for allowing me to testify this morning before your subcommittee concerning the very real problem our nation's shifting veteran population will create for Veterans Administration health care facilities in my state of Florida.

As you are well aware, Florida's veterans population is projected to double by the turn of the century, while the veterans population in the remainder of the nation declines by 10 percent over the same time period. The major cause of this influx of veterans is the continuation of the in-migration of the general population to Florida.

Even more serious than the population gains is the fact that a large number of our nation's veterans, and a proportionally greater number in Florida, are reaching retirement age. As a matter of fact, Florida's veterans have the highest average age in the nation, and by the year 2000, more than 42 percent of the state's veterans will be over 65. With age, the need for more frequent hospital care increases and the period of hospitalization becomes longer. With a growing and aging population, our state's limited health care resources are going to be stretched thinner and thinner if action is not taken.

We cannot be lulled into a false sense of security by the thought that we have several years to plan for the increased demand on Veterans Administration health care facilities. The fact is that the average age of those Americans who bravely served our country in World War II is now 62.6 years, so in less than three years they will become eligible for free medical care.

The combined demographic impact of the population shift to the Sunbelt, and the aging of our veterans population will have an effect on VA health care facilities very similar to the effect the World War II "baby boom" had on our nation's schools during the 1950's. While the growth in the student population was handled 30 years ago through a series of makeshift provisions, the answers to the pending veterans health care problems will not be as easy. Our nation pledged to provide the best in medical services to the men and women who dedicated themselves to protecting our freedoms. Clearly, makeshift health care solutions would be unacceptable in meeting the needs of our aging veterans who are now in a position to collect the dues they earned through their service.

As a member of the Appropriations Subcommittee which oversees funding for the Veterans Administration, I remain committed to ensuring that our nations's veterans receive top-of-the-line health care, and nothing less.

When I was elected to the House of Representatives 12 years ago, I anticipated the great demand that would be placed someday on the VA's health care facilities. That is why I set as my major goal the construction of a replacement hospital at Bay Pines, Florida, to provide the nation's best possible health care for the growing veterans population along the states' west coast.

My dream became a reality in 1974 when you and my other colleagues approved funding for this project, and Mr. Chairman, I am pleased to tell you today, that if all continues along according to schedule, the new 520-bed hospital at Bay Pines will open this February to complete the project, that also includes a 120-bed nursing home and a 200-bed domiciliary, which are both already in operation.

The construction of new hospitals and medical facilities is only part of the issue that must be addressed if we are to meet the projected veterans health care demands in our state. Without the addition of larger numbers of qualified people to serve those requiring health care, new and expanded VA facilities throughout Florida will be under-utilized and will fall short of their fullest potential.

For instance, the new hospital at Bay Pines will provide twice as much floor space as the old facility and will house the newest and most advanced medical equipment. The result will be better, more efficient medical care with a higher bed turnover rate, meaning more veterans can be served in a shorter period of time. However, without proper staffing levels, the new hospital's patient care goals cannot possibly be met.

That is why I am pleased that the Veterans Administration is conducting a special study in Florida to determine the health care staffing and facility needs to meet the growing population needs. In addition, the VA is preparing to undertake a newly developed evaluation of resources throughout the nation that will eventually allow the administration to shift veterans resources from states with declining veterans populations to states, such as Florida, which need to meet critical new demands for health services. This program, known as Medical District Initiated Program Planning (MEDIPP), will help us in Florida provide those veterans who move to our state from all parts of the country, with equal if not better medical service than they received before their move.

Mr. Chairman, these Veterans Administration reviews and hearings such as this one are vital if we are to meet the needs of the aging veteran population. I want to commend you and the members of your subcommittee for scheduling this hearing, and any hearings in the future, to address the very great and pressing veterans needs our state faces in the coming years. My record of support for Veterans Administration programs is clear, and I want you to know that I am ready to assist your committee in any way as we fulfill our responsibility to provide the best possible medical care for those Americans who served our nation so well.

Thank you very much.

PREPARED STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, Members of the Subcommittee, I am pleased to appear today and testify on the health care provided to veterans in Florida. This hearing is another example of your commitment to the veterans who have served in this nation's armed forces.

Mr. Chairman, outside the Veterans Administration building here in Washington is a quote of President Lincoln. Quite simple and to the point it says, "to care for him who shall have borne the battle, and for his widow, and his orphan." We are at a crossroads in terms of the quality and availability of health care we can provide to veterans in Florida. We are at a crossroads because of the projected increase in the number of veterans who will come to Florida and the type of budgetary constraints we are facing these days. In a recent briefing for the Florida Congressional Delegation, a VA official told us that "the steadily increasing demand for services and the decline in the purchasing power of the dollar has put substantial pressure upon our individual Medical Center's ability to provide comparable access to care. This is particularly true at the Veterans Administration Medical Center in Miami." If the Administration further reduces the VA budget, knowing full well that the demand for services will keep increasing, the results will be predictable and disastrous. We will be faced with making the choice of which veteran is more deserving of VA care. We will see a decline in the quality of care and a decline in the VA medical system as a whole.

The problem in Florida is already acute. In Fiscal Year 1981, Medical District 12, which is comprised primarily of Florida, had an estimated veteran population of 1.4 million, which is approximately 5 percent of the total veteran population. Great efforts are being made to correct deficiencies in care that is being provided. But we still need to do more right now. In Miami alone, we need to expand facilities. There is a need for long-term psychiatric beds, additional nursing home space and adequate funding for outpatient care. In 1981, 61 percent of outpatient service was for

service-connected veterans in Florida—well above the 47 percent nationwide average. This is a result of the growing demand for services, coupled with the priority system that was established by Congress and is an indication of the reduction in the availability of health care for veterans that is being brought about by budgetary constraints.

Mr. Chairman, I mentioned that the problem would be getting worse unless we act now. According to the VA, the number of veterans 65 and older is projected to increase by 382 percent by 1990, while the total veteran population is expected to decline 10 percent nationwide. Projections by the Florida Department of Veteran and Community Affairs show that by the year 2000, there will be a 550 percent increase in veterans between ages 65 and 74 in Florida, while a 168 percent increase is projected nationwide. There will be a 775 percent increase in veterans over 75 in Florida, while a 335 percent increase in this age group is projected nationwide.

We have to prepare Florida, as well as the nation, for the future. We can choose to follow a course that will provide funding for an adequate level of care, and a sufficient number of trained staff and facilities; or, we can choose to follow a course that will result in the diminished quality and availability of health care for our veteran population.

Mr. Chairman, I think it is appropriate to reflect on our commitment to the people who have served in the armed forces. We ask, and at times we demand, that the citizens of this nation serve in the armed forces. We also have made the decision that we should provide health care for these veterans. I cannot believe that this nation is so poor or so weak that we cannot provide health care for those people who served in the defense of our country. I look forward to working with the Committee to ensure that now, and in the future, that we "care for him who shall have borne the battle, and for his widow, and his orphan."

Mr. Chairman, thank you again for this opportunity to appear before the Subcommittee.

PREPARED STATEMENT OF HON. E. CLAY SHAW, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Good morning, Mr. Chairman and members of this Subcommittee, I deeply appreciate having this opportunity to discuss with you an issue of vital concern to the American war veterans in Florida. Quite simply, in the State of Florida, the Veterans Administration is not able to meet its responsibility to provide for the health care needs of our veterans.

The situation is bad, and as our veterans population increases, it will get worse.

Today, in my own home district in Broward County, Florida, one out of every seven residents is a veteran. And each month 4,000 to 5,000 new veterans move to our state.

So, as I speak before you today, I bring to you the concerns of a sizeable number of residents in my home district and in my home state.

Time and time again, when I meet with veterans, and with the leaders of their organizations, they tell me horror stories that are increasingly a part of any encounter with a Veterans Administration medical facility.

Just this past month, members of Florida's Congressional Delegation joined in a meeting with representatives of the Veterans Administration to talk about these problems.

Some of the issues we raised bear repeating in this forum.

It galls me to think that a veteran has to wait hour upon hour before receiving treatment at a VA hospital or clinic, yet in South Florida this has become the rule rather than the exception. This is wrong.

I am told this is because of staff shortages. It is no doubt difficult to recruit highly qualified staff while competing with the fringe benefits private facilities can offer. But that information can be of little comfort to the veterans in need of medical care.

From what the veterans in my district tell me, the VA apparently displays little regard for the sound management practices of proper record-keeping and scheduling. Often, this results in nothing more than an inconvenience for our veterans. A pain in the neck. But too frequently, this is a far more serious matter. In some cases, treatment must be curtailed until a patient's records can be found. And I shudder to think of emergency situations when the hospital staff is not provided immediate access to vital medical information.

These management problems are often exacerbated by communication breakdowns within the facilities. It appears to me, that on top of everything else, our veterans are being treated discourteously, and that I find unconscionable.

This spring, I was proud to participate in the dedication of the Broward County Veteran's Outpatient Clinic. It is a fine facility that provides outpatient medical care in a cost effective and efficient manner. I hope the VA uses this facility as a model for clinics around the country.

But even this shining star has a dark cloud hovering over it. Many handicapped veterans are not able to take advantage of the services this facility provides, because the Broward County VA does not have any mode of public transportation that will accommodate wheel-chairs. These are the very individuals we should be doing everything we can to help, and the fact that they have been summarily overlooked is appalling.

Finally, I would like to share with you the concerns many veterans, especially Vietnam veterans, have about the availability of psychological care. I am sure that the VA understands the importance of psychological care in the total health care picture. Yet for many veterans in South Florida, there is little to satisfy this need.

This year in Florida, the Veterans Administration budget will exceed $1.3 billion. Clearly, what the VA does not need is a blank check. What they do need to do is to take a cold, hard look at the way their health care programs are administered. I am here today to point out some of the problems we have in South Florida. I cannot speak for the rest of the country, but I suspect the concerns I expressed today are shared by veterans from Maine to California.

It is my hope that as a result of this hearing we will see some evidence that the VA will try to solve the problems that it has, so that it may properly plan for the needs of the veterans of the future.

PREPARED STATEMENT OF HON. DANIEL A. MICA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Dear Mr. Chairman and members of the committee, I would like to take this opportunity to thank Chairman Mottl for his assistance and support in reviewing the needs of the veterans hospital and health care needs in the State of Florida. As Florida's only member on the House Veterans' Affairs Committee I am particularly aware of the special urgent needs of the veterans of Florida. Florida has the fastest growing veteran population in the Nation, and the average veteran in the State is older than his counterpart nationwide, making him more likely to need some form of health care. Presently, Florida has over 1.3-million veterans with a projected number of 2-million by 1990, and Palm Beach and Broward Counties expect growth rates of almost 80 percent of the present population by 1990.

There are approximately 3,000 to 5,000 veterans moving to Florida monthly, and the trend is to move to the Sunbelt District. Within the Sunbelt, Florida is and will continue to be the State with the fastest growing veteran population. For this reason, I have introduced legislation to require the Adinistrator of the Veterans Administration to consider the number of veterans residing in each State, and the projected changes in the number of veterans residing in each State, in acquiring and operating medical facilities.

Last year I requested that the VA conduct a study to review the demand of VA health care services in Florida with a look at the existing VA facilities, and analysis of the need for expansion and implementation of necessary expansion. This study will be completed and presented to the Congress by November 30, 1982. At the direction of the chairman of the Veterans Affairs Committee, G. V. Montgomery, I was asked to tour, and evaluate the veterans health care facilities in the State of Florida. This gave me the opportunity to view firsthand the existing problems of the Florida VA medical facilities. This tour made me painfully aware of Florida's need for additional funding for outpatient treatment and an additional medical center to alleviate the over crowding of existing hospitals. Because of this, I have introduced legislation requesting construction for a new VA hospital in Florida.

In summary, the increasing number of veterans in Florida has put a tremendous strain on the medical health care facilities. The Florida health care facilities are overcrowded, understaffed and in desperate need of new equipment. It is my hope, and desire that the hearing today will be the beginning of a unified move to support and new medical facility in the State of Florida. Again, Mr. Chairman, and members of the committee I am grateful that you have allowed me the opportunity to express my support for a better health care system for the veterans of Florida.

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
THE JAMES A. HALEY VETERANS HOSPITAL
TAMPA, FLORIDA

I. INTRODUCTION

A regularly scheduled visit to The James A. Haley Veterans Hospital, Tampa, Florida, was conducted during the week of August 31, 1981 to assess the quality, quantity, and timeliness of health care being provided to veterans.

Coordination: Letters of notification were sent to Mr. Richard A. Silver, Hospital Director, and to the following American Legion Representatives, Department of Florida: Mr. Dyke E. Shannon, Department Adjutant; Mr. Robert R. Erskine, Department Service Officer, and Mr. Charles A. Joyner, the VAVS Representative.

During our initial visit the Director was out of town. Mr. McDonald and I talked with the Assistant Director regarding the present and future plans of the hospital and the related problems.

At the completion of this visit we met with the Director, Assistant Director, and Chief of Staff to discuss our observations and conclusions.

Statistical information pertaining to personnel strength, patients on the rolls, and operating costs is attached.

Professional Affiliation: This VA hospital is affiliated with the University of South Florida (USF) College of Medicine. The Assistant Director said there was a fairly good relationship between the school and the hospital, but that there are still many growing pains. In the past 7 years there have been 3 to 4 Deans.

The service organization representative on the Dean's Committee is Robert R. Erskine.

Hospital Accreditation: The Joint Commission on Accreditation of Hospitals (JCAH) surveyed this facility on January 19-22, 1981. A two year accreditation was awarded in all areas with only minor deficiencies cited.

MISSION OF MEDICAL CENTER

The mission of The James A. Haley Veterans Administration Hospital (VAH) is to provide primary, secondary, and tertiary health care. All subspecialty services are available in the major bed services of medicine, psychiatry, and surgery. Ambulatory care services are provided at the hospital and at the Orlando, Florida satellite clinic.

Through the Medical School Affiliation there are 105 postgraduate residency positions in medicine, surgery, psychiatry, neurology, pathology, radiology, and dentistry. There are also a number of subspecialty training programs.

Important research in 25 funded projects concerned with cancer, alcoholism, and metabolic and psychiatric diseases help improve the facilities diagnostic and treatment capabilities and the recruitment and retention of highly specialized staff.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: According to the Assistant Director, the funds for Fiscal Year 1982 (FY 82) will not be adequate to meet the increasing number of veterans using this hospital. Overall staffing was described as sufficient, but proper pay rates were not. Some specialty areas are difficult to staff for this reason.

Land at this hospital is at a premium. With the continual growth and expansion more is needed. Two lots at the rear of the hospital have been for sale for a number of years. (One is 16.4 acres; the other is 4 acres). Many requests have gone to Veterans Administration Central Office (VACO) for the purchase of this property.

An area of treatment that needs immediate attention is Radiation Therapy. This service is being contracted out at an enormous cost. For the first half of FY 81 the total came to over $450,000.00. This hospital has been requesting funding for this project since 1975, but VACO keeps moving the starting date back. It is currently scheduled to be included in an addition to the south side of the building in FY 84-85. An interim project is being planned for the west side of the hospital, but not until FY 83.

Overall space in this facility is "shrinking". Many areas are feeling the squeeze. The anticipated number of veterans using this facility has been surpassed. Many non-service-connected veterans (NSC) have to be turned away causing many phone calls and letters from the service organizations and Congress. The Orlando Clinic (approximately 84 miles away), affiliated with this hospital, is also having this problem. Their veteran work load runs over 88% service-connected (SC).

The telephone system at this VAH is in dire need of updating. Calls in and out are often misdirected or never completed. Many requests have gone to VACO to have the main switchboard modernized.

Early next year a 120 bed, two story Nursing Home Care Unit (NHCU) will be constructed in front of the hospital. It is being designed to accommodate the erection of an additional 120 bed unit in the future.

Professional Services: The Chief of Staff (COS) said that virtually all of his physicians are board certified. All three major Service Chiefs, the Chief of X-Ray, and Chief of Nuclear Medicine attend or are members of the Dean's Committee.

The COS reported that the 813 funds used for education are not adequate. Even with a rationing of 75% of the total cost, up to $300.00, the funds had been depleted three weeks prior to our visit.

The Chief feels that this VAH is in a delicate situation at present. They are not in a position to sell services, only to buy. Currently, Computerized Axial Tomography (CAT) Scans are done on a fee basis averaging $465,000.00 a year. A mobile (body and head) CAT Scanner is outside of Ambulatory Care. This situation should be rectified in February, 1982, with the installation of a CAT Scanner in radiology on the first floor.

Another exigency is the lack of Radiation Therapy. The only good hospial in the area providing this service is 12 miles away. Since 1975,the costs have risen 429%.

ANALYSIS OF RADIATION THERAPY

FY	# PATIENTS TREATED	ANNUAL COST
1975	300	$148,127.00
1982 (Projected)	575	$900,000.00

A state funded 150 bed Cancer Research Hospital is being planned for the USF campus starting within a year. A Radiation Treatment Center is to be included in this project. If the VAH is not able to start their program soon, they will be buying this costly service from the university. The proposed interim project will not be operational until 1985.

Another problem is the equipment failures in the Cardiac Catheterization Laboratory. The COS said new equipment has been ordered for this delicate treatment area.

Assistant Director: The Assistant Hospital Director (AHD) said the services under her jurisdiction are improving. There were some problem areas, but personnel changes rectified these situations.

Office of Management and Budget Circular A-76 (OMB A-76) has caused some unrest. The AHD said that the administration has been performing internal public relations to assure the employees that the front office is behind them 100%. In spite of this, some employees have gone to Personnel Service to see if there are other hospital openings to which they could transfer.

A good Security Service is having some problems because of the rising crime rate in the Tampa area. This area will be discussed later in the report.

Parking continues to be a growing pain. The original 700 parking spaces have been doubled, but this is still inadequate for the increasing traffic pattern at this facility. When the on site construction commences and the State of Florida widens the two lane highway in front of the hospital to six lanes, over 400 parking spaces will be lost. If the VA would purchase the two lots at the rear of the hospital, it would alleviate the parking situation.

Security Service: The Chief of Security feels his staff of 12 policemen do outstanding work, but he would like to have two more supervisors for the late shifts and an investigator to handle detailed and time consuming cases.

After the main security station was moved to the Emergency Room entrance, incidents dropped by 50%.

A good surveillance system complements this service. Six outside cameras cover all sides of the building and the four inside cameras are located in the outpatient area, front lobby, and vending and retail areas of the canteen. Requests for one at the credit union and the new pharamacy have been sent to management.

There are no marked patrol cars at this hospital, but the Chief said he gets excellent support from the USF Police and the Hillsborough County Sheriff's Department. He has an agreement with both to drive through the VAH parking lots when they make their rounds.

Each shift has at least two officers covering, and at night all the hospital doors are locked, except at the emergency entrance.

Even with all these safety procedures there is still a large amount of criminal activity. Vandalism, theft, and drug activity are the most common. An average of one automobile a year is stolen. From December, 1980 thru August, 1981 government and personal property stolen totalled $6,312.00 and $7,077.00 respectively.

Many patients and visitors carry concealed weapons of all types. The worse incident occurred about two years ago when a person barricaded himself and a staff member behind a counter. He had been drinking and was making threats with a gun, but after five hours he let the hostage go and gave up.

REGIONALIZATION

This facility is in District #12 of Region #3 (Southeasten). The AHD said that there was little contact with the field staff, but a good rapport existed with VACO. She feels that the Florida hospitals are not getting their "share of the pie".

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

On their first day of employment personnel are briefed on their benefits, etc. Once a quarter all new employees are oriented to the hospital with films and speakers including the Director, Assistant Director, and Chief of Security.

Security provides education in fire and personal safety techniques.

Nursing provides continuous medical training, which is a requirement for license renewal in the State of Florida.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

The outpatient (OPT) visits funded for this facility total 140,000. In FY 80, there were 141,026 visits and through July FY 81 there had been 117,201.

The space for this busy area is "shrinking". There are 12 outpatient examination rooms and 29 rooms in the specialty clinics. Additional space will be realized with the new South Wing Addition scheduled for FY 85.

Support services were described as good. Satellite Lab and x-ray rooms are in the OPT area for routine procedures. Emergency electrocardiograms (EKG) can be done here, but routine tracings are done on the 6th floor.

A Processing Time Study (PTS) for walk-in patients was conducted July 27-30, 1981. The overall average time from check-in to check-out was two hours and twenty minutes.

Orlando, Florida Outpatient Clinic: This two floor outpatient clinic opened during November, 1974 and is under the jurisdiction of VAMC Tampa, Florida. Due to the tremendous work load a one floor addition was constructed. The addition was occupied in January, 1981.

The goal of this clinic is to provide quality outpatient care to as many eligible veterans in the area as possible. The clinic operates from 8:00 a.m.-4:30 p.m. Monday through Friday. Early appointments are acknowledged at 7:30 a.m.

Services available include: Internal Medicine, Orthopedics, Urology, Cardiology, Ear, Nose and Throat, Ophthalmology, Gastroenterology, Psychiatry, Dental, and Diagnostic x-ray. Additionally, the clinic has a physical therapy section, a nutritionist,

clinical laboratory, and social work service. Consultation is available in dermatology, podiatry, and neurology.

If hospitalization is required,veterans are admitted at either VAMC Tampa or Gainesville depending upon the location of their residence.

This Clinic cannot meet the demand for care in the Orlando area. The acceptance of new applicants must be restricted. Veterans with service-connected disabilities are in the highest priority category.

A veteran's benefits office is also staffed to assist and advise veterans on their claims and benefits.

There are 90.3 FTE positions at present. The need was expressed for two nursing assistants to be assigned in the reception areas. Their presence would provide a security need for occasional problems that currently exist on occasion.

Work load has increased considerably since Fiscal Year 1975. The last 6 months of that year revealed 13,593 visits. Fiscal Year 1980, 57,241 visits and as of July 31, 1981, 51,074 visits were realized. A request has been made for an additional 30,000 visits for FY 82 which would authorize a total of 80,000 visits.

Because of the tremendous service-connected work load only 12 percent of non-service-connected veterans are treated. Six percent are World War I veterans and six percent are receiving aid and attendance. Two years ago 35 percent of NSC veterans coming to the clinic were assisted. All other non-service-connected veterans are only seen for evaluation for hospitalization. They are not picked up on the rolls. The ongoing process now is weeding out those non-service-connected veterans that have been on the rolls for a few years.

There is a demand for a Day Treatment Center. Space has been made available for this purpose. One psychiatrist, 1 nurse practitioner, and 1 recreational specialist will be needed to institute the program.

Audiology equipment has been purchased, however,no staffing has been provided. One full-time audiology position is needed.

The need for a dialysis section is also needed according to the physician in charge. It was indicated that hospital management is studying the need for this program.

The Joint Commission on Accreditation of Hospitals recommended that an answering service be utilized for weekend calls.

A small canteen will be opened once the contract is completed.

The Henderson Ambulance Company has the monopoly on this service in the Orlando area. Within Orlando City limits rates are $55.00-$60.00. It is nearly impossible to transport a patient to VAMC Tampa by this ambulance company. Medical Center management should study this problem and provide a solution.

During the Wednesday noon working lunch,physicians discussed the problem of missing charts. Charts are forwarded to VAMC's Tampa or Gainesville on outpatient's referral. It is this surveyor's thought that if this problem has been identified, why can't management at all three facilities develop a workable solution?

MEDICAL ADMINISTRATION SERVICE

The 697 operating beds for this hospital are distributed as follows:

Psychiatry	150
Medical	217*
Surgical	248
Spinal Cord Injury	42
Neurology	20
Rehabilitation	20

*Includes 10 Hemodialysis beds not available for overnight occupancy.

Inpatient statistics for the hospital and by bed service in FY 81 (October through July).

	ADC	BED OCCUPANCY(%)	ADMISSION	PTS. TREATED	*TURNOVER(%)	LOS
Hospital	544	78.1	17,363	18,397	*320.2	13
Medical	169	77.9	10,971	11,058	*639.6	7
Surgical	184	74.2	4,287	4,724	237.5	13
Psychiatry	123	82.0	1,458	1,748	122.8	25
Spinal Cord	38	90.5	262	362	73.7	43
Neurology	14	70.0	330	361	242.9	12
RMS	16	80.0	55	144	68.8	56

*Includes one day admissions for Hemodialysis.

The percentage of admissions by period of service is:

Over age 65 (includes WWI)	23.5%
Vietnam	16.0%
All others (includes WWII, Korea)	60.5%

Of the 419 Compensation and Pension Examination (Form 2507) currently pending 99% are less than 6 months.

The acceptance rate for Applications for Medical Care (VA Form 10-10) was over 88% through July 31, 1981.

The Chief of MAS had only been at the Tampa VAH a week during our survey. He felt a number of changes would help improve his service. Centralized Scheduling is an area to be upgraded. The Chief felt it was a misnomer to call it Centralized Scheduling because it didn't include some clinics.

He described his staff as good, but the ward clerks were limited after 4 o'clock and weekends.

BED SERVICES

Medical Service: The 217 beds in this service includes a 5 bed Cardiac Care Unit (MICU), and a 4 bed Respiratory Intensive Care Unit (RICU).

All space was described as good except in the RICU and the Cardiac Catheterization Laboratory (CCL). The tight space in the RICU should be eased with the addition of nearby storage areas. The expansion of the unit itself is prohibited by pipes running through the walls.

The Chief of Medicine was very vocal concerning his feelings for the CCL. The equipment is outdated and numerous times has broken down during a delicate procedure. These dangerous occurrences should be rectified when the new equipment for this lab is installed. The Chief was also concerned with the location of the lab. It is currently on the 7th floor. He feels it should be closer to the Cardiac Operating Room (OR) which is on the 2nd floor. The elevators are always busy and slow. The Chief feels that in an emergency, the time delay is very critical to the veteran. He would not committ himself to the possible number of life threatening incidents that may have occurred. Four to five hundred procedures are done in this lab each year.

During the exit interview the Director said he was unaware that space for the new CCL equipment was an issue. He said there was available space on the 7th floor for the lab, but none on the 2nd. He also said that two new elevators being added to the hospital should help alleviate the heavy traffic patterns at the other lifts.

As of September 21, 1981 an agreement as to the location of this lab had not been realized.

Spinal Cord Injury (SCI): This very busy service runs over 90% occupancy each year with a regular waiting list.

Staffing for this area is very good, but because of the daily demands put on them by the patients, the turnover rate fluctuates greatly. There is no incentive pay for the nursing staff, so many transfer to less stressful areas. Many staff meetings are held, sometimes with the veterans to try to keep the morale high and to air any bad feelings.

The 42 bed unit is split into two teams: the "clean" and the "dirty". Here "dirty" refers to patients who have developed pressure sores and need special care to avoid the spread of infection. Presently, one of the improved methods is the use of "air beds". These are beds that have mattresses filled with silicone beads that allows air to flow through freely. They can also be temperature regulated. Currently, three beds are available, but requests for additional ones have been sent to management.

The acting Chief of the SCI Unit said that most veterans were here due to shallow water diving, motorcycle accidents, auto accidents, and gun shot wounds.

Discharged patients are readmitted every 6 months for 3-4 days for testing. Urinary tract infection is the "leading cause of death" in SCI patients, so they are closely monitored and treated.

Outpatients fluctuate between 700-1,000 each year. The reason given for this was the large number of transients in Florida.

A 20 patient Hospital Based Home Care (HBHC) Program is provided for veterans who live within a 50 mile radius of Tampa. The average length of stay (ALOS) depends on how quickly the veteran and his family adjust to their new situation.

Therapies and training provided to this area are: bowel care, occupational therapy, correctional therapy, rehabilitation therapy, warm waterpool treatments,

painting, driver training, and educational therapy. The educational therapy is for the patients and their families.

Space on this 42 bed unit is limited and many items have to be stored in the hallways or bowel care rooms. This problem should be eliminated when the new addition is added and this area is refurbished. The 100 bed (60 chronic, 40 acute) unit is planned for FY 86.

Surgical Service has a total of 248 beds, which includes a 10 bed Surgical Intensive Care Unit (SICU). Four SICU beds are being added when the construction in progress is completed. There is also an 8 bed recovery room.

The Chief of Surgery said he has a "very good staff", but feels he needs more. He said he is only staffed for 7 of the 8 operating and 2 cystoscopy rooms. Requests for 2 nurse anesthetists, 2 registered nurses, 1 OR technician, and a 0.5 anesthesiologist have been sent to VACO.

Backlogs were noted in the following areas:

Vascular	70	patients
Plastic	55	patients
Orthopedics	4	months
General Surgery	2-8	weeks

Many scheduled procedures have to be rescheduled when emergencies arise. The Chief said they try to do as much outpatient surgery as possible to disperse the work load.

Equipment for the SICU was described as adequate, but would have to be replaced before the South Wing addition is built if VACO continues to delay its construction. The new wing is to include a 20 SICU.

The only surgery not performed at this facility is organ transplant.

Alcohol Treatment Program (ATP): The ATP has been operational for 5 years, but has never been funded by VACO. Requests for the funding were related as being "delayed".

The staff consists of:

1	Master Social Worker
1	Psychiatric Technician
1	Psychiatrist (Coordinator)
15	Nursing Personnel

There are no alcohol counselors. A nurse clinician was lost through attrition and the coordinator is out with a heart attack.

Prior to admission to this 30 bed unit a veteran must sign a treatment contract that includes the following:

1. Minimum stay of 30 days.
2. Take antabuse while in the program and up to 6 months after discharge (unless medically contraindicated).
3. Take no medications unless part of the treatment.
4. A minimum of a 6 month follow-up.

There is one "standing rule"; no one is eligible for readmission for at least six months.

The main concept of the program is community living. A patient government is used.

If a veteran is caught drinking during the program he is put on a two week restriction and the rest of the community is put on a one week restriction. If a veteran turns himself in to another patient, who in turn passes the information on to the staff, the community restriction is lifted. The philosophy is that, "you are responsible for your behavior and your behavior affects all those around you".

The average stay in the inpatient program is 60 days, the maximum being 90 days. There are no contract Halfway Houses used, but referrals are made when necessary.

Psychiatry Service: The 150 beds in this service are allocated as follows:

Acute	60
Geriatric	30
Alcohol Treatment	30
Long Term	30

The Chief of Psychiatry said the poor community resources for this type of patient caused a "revolving door" policy at the hospital. The VA provides a Mental Health Clinic and Day Hospital at this site and a Day Treatment Program at a downtown location, but they are unable to handle the estimated 1,800 admissions a year to this service.

Staffing was described as adequate, except in the outpatient area. One physician on the Geriatric Unit was leaving, but recruitment for the position was in progress.

Therapies used are: occupational, physical, corrective, chemo, and group. Very little electroconvulsive therapy (ECT) is used. The Vocational Rehabilitation Program was described as excellent.

Shortcomings for the psychiatric units were the lack of security buttons (call for help) and seclusion rooms. Incidents were said to be low.

The Day Hospital (DH) is set up for short term treatment of psychiatric patients to aid them in adjustments into society. The maximum stay is 4½ months with the average running 3 months.

The program is run 5 days a week during regular working hours. A hot line is manned by volunteers in the evenings and on weekends.

Fifteen patients are currently on the rolls, but they can carry up to 26. Although there are referrals from both inpatient and outpatient sources, there hasn't been a waiting list.

As a patient progresses in the program the daily visits are weaned to as few as can be handled. Some patients work and are only part-time.

The "community" makes their own rules with officers elected every two weeks. If a community member misses 3 unexcused meetings in a row,he is discharged from the program.

There are very few repeaters to the program. For a member to return he has to be facing a different crisis.

Space was described as good in the new one story building behind the hospital. The big problem was poor soundproofing. Although the walls are 6 inches thick, you can hear everything that is being said in the next room. Management said they would attempt to rectify the situation.

The Day Treatment Program (DTP) is set up for the chronic psychiatric patient. Although there is no time limit, the ALOS is 1½ years.

When the program was first created in October 1974, it was housed at the VAH. In October 1977 it was moved 10 miles away to its present location in Tampa.

The space consists of 7 offices, 2 classrooms, a large all purpose room, quiet room, OT room, kitchen, and separate men's and women's bathrooms.

The patient ceiling is 60. Currently, there are 56 patients and a waiting list of 20. Turnover is very low.

Programs are run four days a week with Fridays set aside for staff paperwork in the morning and patient staff socialization in the afternoon.

Eighty percent of the veterans have physical disabilities as well as psychiatric problems. Two are wheelchair patients.

Staff shortages are: 1 registered nurse, 1 recreational therapist, and 1 physical therapist. Attempts are being made to get the latter from a volunteer service from the county.

A priority for this service is a wheelchair accessible vehicle. Presently, they have limited use (once a month) of the hospital bus.

Rehabilitation Medicine Service (RMS): The ALOS for veterans on this 20 bed unit is 56 days.

Therapies and staff are provided in the following areas:

Corrective Therapy: 8 therapists
Occupational Therapy: 9 therapists
Physical Therapy: 8 therapists and 2 assistants
Vocational Rehabilitation: 4 therapists and 2 assistants
Educational Therapy: 2 community teachers, not paid by the VA, are provided by the Hillsborough County Adult Education Program.

Also provided at this facility is a Horticultural Therapy Program, with a greenhouse and slot house; a Driver Training Program, with two simulators, two vans, and one automobile; and a Vocational Counseling Program. This last program provides education, training, and job placement and follow-up. A counselor from the State of Florida Employment Service assists veterans 2-4 days a week and once a week a person from the State Vocational Rehabilitation Program provides time to the veteran. All the VAH provides these state representatives is office space to work from.

The average number of patients seen each day is 230.

Space was described as good except in 3 clinics: prosthetics, orthotic, and wheelchair.

MEDICAL SUPPORTIVE SERVICES

Audiology and Speech Pathology (A&SP): The Chief of A&SP said the catchment area for his service includes 8 counties north of Tampa to the border and a few counties in Georgia. He also carries a minisupply of hearing aids for the Gainesville VAMC and Jacksonville Outpatient Clinic (OPC). The Orlando OPC is in the process of setting up a satellite service to be operational October, 1981. It will have to be run on a fee basis until there is funding for regular VA staff.

In FY 80, 622 SC and 289 NSC veterans were given hearing aids. Total visits in Audiology for FY 80 were 4,193. In Speech Pathology the total visits were 4,824 for the same period. Both of these figures are running slightly higher in FY 81.

Space for this area was described as good. The 3 sound rooms were well insulated and away from the main traffic stream.

The Chief said he was short one Speech Pathologist that he lost during the 1975 hiring freeze. He said he will need this position filled when the new NHCU is opened.

Many phone calls have been received by this service regarding hearing aid batteries not being sent to the veterans. When the Chief called Denver, he was told that they were out of #675 batteries and they were hopeful their supply would be in the following week. A call was made to the A&SP Service on September 23, 1981. I was told that the problem had ebbed.

Pharmacy Service: The pharmacy is in the process of moving part of their service. The shafts for two new elevators are being erected in this area. A gain of 700 square feet will be realized with this move.

This service is well staffed and handles an average 2,500 outpatient prescriptions each day (800 mailouts, 1,700 window). The average turnaround times are:

Mailouts	24 hours
Window	45 minutes

Window hours are: 8 a.m. to 8 p.m. Monday through Friday, and 8 a.m. to noon on Saturday. Emergencies are handled anytime.

The Unit Dose and IV Additive Programs for inpatients are operating 24 hours a day.

The Chief said his staff is becoming apprehensive regarding the cost studies being prepared for OMB A-76. These preparations start in March 1982.

Implementation of the Automated Prescription Processing, Labeling, Evaluation, and Storage (APPLES) System is planned for FY 83-84. Currently, only automatic typewriters are used for labeling purposes.

Nursing Service: The Chief of Nursing said that the VAH in Tampa could not compete with the private sector in wages or benefits. There are 51 registered nurses (RNs) and 63 licensed practical nurses (LPNs) resignations in one year's time. During our visit she was preparing a package for VACO of a comparison salary survey she had done on the community hospitals. A proposal for special salary rates is being included. She feels

that without some type of beneficial incentives, her ability to recruit and retain a quality staff is limited.

Additional support is needed from MAS and Building Management Service on the evening and night shifts. Often nursing personnel must perform clerical and housekeeping duties. This is valuable time being taken away from patient care.

Social Work Service: The Chief of Social Work Service said he had a very good staff. Twenty-nine Master Social Workers (MSW) are assigned to the hospital and 6 MSW are assigned to the Orlando Clinic.

Two of the MSW in the hospital are assigned to the outpatient and ambulatory care. When NSC veterans are ineligible for treatment, they are given referrals to community resources.

Two resources lacking in the community for referrals are for the aged and psychiatric veterans. In psychiatry, neither the VA nor the State of Florida have long term care facilities.

The Residential Home Care (RHC) Program boasts 14 homes and 20 placements. One MSW operates this program.

ANCILLARY SERVICES

Dietetics Service: The largest problem in this service is the looming shadow of OMB A-76. The Chief of Dietetics said a large amount of time and money are being spent on the paperwork, preparing for the cost studies. She said that staff morale is being affected by this problem. One staff had resigned.

Dietetics Service prepares 3 meals a day for approximately 600 patients and volunteers at a raw ration cost of $3.56.

Ninety percent of the food served is convenience foods. Thirty-eight percent of the diets are modified. The pellet system is used to deliver food to the bedside. Dining rooms on the first and second floors are for patients capable of using them.

After talking to patients, and eating a noon meal myself, it is obvious that the food is of good quality, quantity, and taste.

Veterans Administration Voluntary Service (VAVS): The Chief of VAVS said 37 organizations comprise his service. The 750 regularly scheduled volunteers and the approximately 250 occasional volunteers contributed a combined a total of 143,000 hours in FY 80.

The American Legion Representative is Mr. Charles Joyner. His deputies are Mr. Frank Caron and Mr. William Webster. The 55 American Legion volunteers accumulated 1,658 visits for a total of 10,824 hours during the first 10 months of FY 81.

The American Legion Auxiliary representative is Mrs. Gaynell Anderson. Her deputies are Mrs. Eloise Pany, Mrs. Louise Sisk, and Mrs. Leona Stuall. The 60 Auxiliary volunteers provided 11,191 hours during 1,689 visits from October 1980 to July 1981.

The Youth Program provided 37 volunteers this past summer. Currently, attempts are being made to set up a credit course at one of the local high schools for these students.

The Assistant Chief of VAVS said that good public relations have been established with the community. Some of the local merchants, such as Dunkin Donuts, provide discounts to this hospital service.

Recreation Service: This service has been under the control of the Assistant Director for the last 2½ years. Prior to that it had been bounced around between RMS and VAVS.

The staff for this service includes four therapists, counting the Chief, and a part-time secretary shared with RMS.

There are few outside facilities at this hospital, so community parks, golf courses, bowling alleys, etc., are used as much as possible. Bedside activities include the leather craft and kit programs. The Chief of Recreation stated the leather craft is an American Legion program.

Evening and weekend activities are called "All Hospital". These social events, such as, bingo and dances are usually run by VAVS volunteers. Once or twice a month there are cookouts on the weekends. Saturday programs usually have poor participation because of weekend passes.

III. CONCLUSIONS

The land at this facility is becoming scarce. The continued veteran growth in Florida is placing a burden on this hospital. To meet this demand, expansion of services will be needed. Acquisition of additional property is a must.

A Radiation Therapy Program at this facility is long overdue. The skyrocketing costs for this treatment cannot be ignored any longer. The VA must be in a position to sell this service, not buy it. Many veterans are now at the age where they will be needing this treatment more frequently.

The Orlando Outpatient Clinic has outgrown the planned visits. Eighty-eight percent of the veterans are service-connected. Additional funds are needed for the increased patient visitations. During our visit the clinic was already 13,000 visits over planned.

The Catheterization Laboratory soon will be getting direly needed equipment. Appropriate space for this equipment must be established for good continuity of patient care.

Nursing wages and incentive pay must be examined and adjusted to keep up with the private sector. The quality of patient care may be jeopardized due to the lack of a supportive staff. The continuous training of new employees is wasted money if they leave for better wages elsewhere.

The phone system at this hospital is taking "steps" backward with each passing day. In this age of electronics the lack of adequate communication capabilities anywhere is deplorable,but especially in a hospital.

After talking with patients and their families, and through my own observations it is clear that this hospital is providing the best possible care to the veterans. Continued support from VACO can only improve this care.

IV. RECOMMENDATIONS

1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize the necessary funds to purchase the two lots (16.4 acres and 4.0 acres) behind VAH, Tampa.

2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize special funding to expedite the construction of the interim Radiation Therapy Center.

3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support the funding needed to increase the outpatient visits at the Orlando Clinic by at least 30,000.

4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize special funds for the Alcohol Treatment Program to meet VACO criteria.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

James A. Haley Veterans Hospital

LOCATION Tampa, FL 33612 DATE OF INFORMATION August 31, 1981

MEDICAL CENTER DIRECTOR Richard A. Silver

ASSISTANT MEDICAL CENTER DIRECTOR Barbara A. Small

CHIEF OF STAFF John T. Riggin, Jr., M.D.

MEDICAL SCHOOL AFFILIATION University of South Florida

	CURRENT* FY 1981	LAST FY 1980
BED CAPACITY	702	702
OPERATING BEDS	697	697
AVERAGE DAILY INPATIENT CENSUS	544	563
OUTPATIENT VISIT (ACCUM.)	117,201 **	141,026
WAITING LIST:		
SERVICE-CONNECTED	-0-	-0-
NONSERVICE-CONNECTED	84	31

EXPLAIN THE REASON FOR THE WAITING LIST:

Currently there are waiting lists for Orthopedic, Vascular Surgery and Spinal Cord Injury services. These waiting lists occur because of the patient volume (demand) for these services exceeds the physicial capabilities of the hospital.

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR	50,351
NUMBER OF APPLICATIONS ACCEPTED	39,616
NUMBER OF APPLICATIONS REJECTED	10,735
APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR	32,329
NUMBER OF APPLICATIONS ACCEPTED	28,478
NUMBER OF APPLICATIONS REJECTED	3,851

*FY 81 data are cumulative thru 7/31/81.
**Effective 1/1/81, Ft. Myers Outpatient Clinic under jurisdiction of VAMC, Bay Pines, FL.

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1798.9

CORE RATIO 2.01 (FY 80)

STAFF PHYSICIANS (FTE) 108.4

CONSULTANTS ON THE ROLLS 62

ATTENDINGS ON THE ROLLS 198

RESIDENTS 112

MEDICAL STUDENTS 96

PHYSICIAN EXTENDERS 10

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) There are no vacancies within available resources.

REGISTERED NURSES None currently.

LICENSED PRACTICAL NURSES Seven (7) currently.

NURSING ASSISTANTS None currently.

OTHERS None currently.

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) TOTAL COMBINED: 158

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED)

SUMMARIES PENDING 24

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE 413

OPERATING BEDS IN NURSING HOME CARE UNITS N/A

FUNDS

AVERAGE COST PER PATIENT DAY $218.68

AVERAGE COST PER OUTPATIENT VISIT $27.84

AVERAGE COST PER NHCU DAY N/A

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES $40.38

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) $60,401,218.

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) $55,530,166.

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
VETERANS ADMINISTRATION MEDICAL CENTER
BAY PINES, FLORIDA

I. INTRODUCTION

During the period of August 24-28, 1981, a visitation of Veterans Administration Medical Center, Bay Pines, Florida, was conducted to evaluate the quality, quantity, and timeliness of health care provided to veterans.

Coordination: Prior to this planned visit letters were forwarded to Mr. Richard F. McElligott, Director, and Messrs. Dyke E. Shannon, Department Adjutant, Robert R. Erskine, Department Service Officer, and Eugene C. Egg, Hospital VAVS Representative, The American Legion, Department of Florida.

At the Medical Center Mr. McDonald and I had our initial meetings with the Director, the Director's Administrative Assistant, and the Acting Assistant Director.

At the completion of this five day survey we met with the Director, Assistant Director, and Chief of Staff to discuss our observations and conclusions.

Veterans Administration Medical Center (VAMC), Bay Pines, Florida consists of 27 buildings on 337 acres of beautifully landscaped and well maintained grounds. The total bed capacity is 1,113 and there are 1,600 parking spaces. There is also a closed 4,200 grave cemetery which dates back to the Indian Wars.

This facility is currently undergoing major construction and renovation. A new 520 bed, six story hospital is being built and is scheduled for completion in the spring of 1983. The new building will have energy saving devices, such as, solar roof panels for heating the hospital's hot water supply. The limited number of windows have been recessed and slanted to keep out the sun's direct rays except in the winter when the sun is lower in the sky.

This fall some of the clinics will begin moving into the new hospital. The downtown outpatient clinic will be moving into this structure and is scheduled to be operating next spring. When the entire hospital is finished, it will have the latest equipment to aid in the veteran's care.

As the old buildings are emptied most will be renovated to meet JCAH criteria for patient privacy, and administrative use. A total of three beds will be lost.

Statistical Information pertaining to personnel strength, patients on the rolls and operating costs is attached.

Professional Affiliation: This Medical Center is not affiliated with any medical school, but a possibility exists that they may become affiliated with the University of South Florida in Tampa. The Director feels that if an affiliation would benefit this Medical Center, he would endorse it. With the large influx of older veterans into Florida a new Geriatric Research, Education and Clinical Center (GRECC) program could be established. The program would need the assistance and medical personnel from a Medical School Affiliation.

Hospital Accreditation: During December 1979, this facility received a two year accreditation in all areas with only minor deficiencies noted. Another Joint

Commission on Accreditation of hospitals (JCAH) survey is being planned for December 1981.

MISSION OF MEDICAL CENTER

The Mission of this Medical Center is to provide primary and secondary care in Medicine, Surgery and Psychiatry. This facility also provides a Domiciliary, a Nursing Home Care Unit (NHCU), and speciality programs in Alcohol Treatment, Mental Hygiene, Respiratory Care, Hospital Based Home Care (HBHC), and a Vietnam Combat Unit. Ambulatory Care Clinics in St. Petersburg and Fort Meyers, Florida are affiliated with this hospital.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: The Director stated that the staffing at this facility is "terrible". "It is one of the lowest in the system." There are 1,113 total beds at this Medical Center. He feels to continue quality care to the ever growing veteran population in Florida, his staffing needs to be increased by 500 personnel. To further magnify the problem the Director said that many of the professional staff are nearing retirement age. Recruitment is on going to bring in younger doctors, but this is a slow process. He feels that an affiliation with a medical school would enhance this recruiting.

The overall funding needs to be increased, but in Fiscal Year 1982 (FY82) monies are being reduced. With the opening of the additional 120 bed nursing home and the 200 bed domiciliary the new funding will be very inadequate. Also of great concern to the Director is the ear marking of funds by Veterans Administration Central Office (VACO). If he is able to save money in one area he is unable to use it in another. This takes the management of the hospital out of the Director's hands.

A grave concern facing the entire hospital is the Office of Management and Budget's Circular A-76 (OMB A-76). Turmoil and apprehension are beginning to echo through the corridors of this facility. There is much concern by the laundry staff. In October 1981, this service, which also does all of the Tampa VA Hospital laundry, will close down for one year for extensive renovation and equipment replacement. While this is being done, a contractor will be doing the laundry, but the laundry personnel believe that this is just the beginning of OMB A-76. The Director feels that OMB A-76 "will be a night mare for the Veterans Administration" and this writer concurs. With all the unrest and morale problems this circular is causing, the quality of patient care is being greatly reduced. Hospital personnel cannot adequately function under an umbrella of limbo.

The Fort Myer Outpatient Clinic came under the Bay Pines jurisdiction in January of this year. It was originally built for 25,000 yearly visits, but with the growing number of veterans moving to Florida the Director feels this number will increase rapidly in the very near future.

Professional Services: The Chief of Staff (COS) stated he has a very fine staff, but their numbers have stayed constant over the past few years while the patient workload has increased markedly. The present staff total is 99 with 33 being board certified, and they are distributed as follows:

VAMC	70
St. Petersburg Clinic	22
Fort Myers Clinic	7

The Chief of Staff said he is currently recruiting for a cardiologist and a gastroenterologist.

We talked about the increasing need for a Computerized Axial Tomography (CAT) Head Scanner. He said that between 50-60 are done each quarter at a cost of $300.00 each,not including travel and medical support. It is six miles round trip and many times patients are too sick to be transported that far. Often it is booked up causing a delay or cancellation of this much needed diagnostic. procedure.

The Chief of Staff said a request for a CAT (head) scanner will be going to Veterans Administration Central Office (VACO) this September when ordering the equipment needed for the new hospital.

The backup services were described as above average. The laboratory was one of a small number nationwide to receive the Burroughs-Wellcome award for accuracy of test results.

Assistant Director: The Acting Assistant Director (AAD) said the services under her control are operating well. Building Management and Engineering staff are both concerned with the future of their jobs because of the aura of OMB A-76, but call-in's have not been increasing.

Security Service was described as good, but very understaffed. There are two on most shifts, but sometimes only one during vacations. Pilfering has been on the increase and there has been a number a recent car thefts.

Since the Medical Center Fire Department was closed a year ago, the duties have been taken over by the Seminole Community Fire Department. They provide periodic fire drills for their staff to see what their response time to the Medical Center will be. They also have been orienting their staff to the new hospital building to familiarize themselves with the inside and best possible approach routes.

Security Service: This service is extremely undermanned. The Chief of Security said he has been trying to get additional staff from Position Management, but this has been denied. He currently has 10 officers besides himself to help patrol this 337 acre facility and its 27 buildings.

The Chief said that the calls for help have doubled since 1979. From January to June 1981 the total number of incidents was 368. Many of these incidents take place near the Admissions Area. One near tragic incident occured about 6:00 p.m. on August 6, 1981. A veteran with his finger on the trigger of a 38 loaded with 5 rounds of hollow point ammunition, walked into the Admissions Office demanding to see a doctor. He pointed the weapon at the Administrative Officer of the Day (AOD). The AOD remained calm and was able to talk the veteran into a room away from the people in the waiting area and subsequently able to persuade the veteran to give up his gun.

From January to June, 1981, 21 assorted weapons have been removed from people at the hospital. Also during the same time period there were 127 personal property thefts totalling $13,774.00 and 37 government property thefts totalling $14,141.00.

All transportation requests are provided by the police after 4:00 p.m., on weekends, and holidays.

The Chief says his officers provide a good response time to incidents. The police station, although centrally located, is quite a distance from the main building and admissions area. This site does not adequately provide the best visibility of officers to the general public and veterans.

Assistance from the Pinellas County Sheriff's Office was described as "outstanding".

A much needed camera, communications, and alarm system has been requested for installation in the new hospital to cover strategic areas in the hospital, and the parking areas and supply docks outside.

The Chief feels his dedicated staff is underpaid. He has a very low turnover rate and has only accumulated 18 days sick-leave this year for 11 men.

The Chief feels that he could provide much more police visibility if he had 2 more officers, an investigator, and an office clerk.

REGIONALIZATION

This VAMC is in Medical District 12 of Region 3 (Southeastern). The Director said there is good open communication with all hospitals in the district and a good sharing agreement with the Tampa VA Hospital. He went on to say that the District Office gave excellent support and guidance.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

All new employees are given handbooks explaining their benefits, responsibilities, etc. After being assigned to their work area additional training is provided.

Continuous education is a mandatory requirement for nursing license renewal in the State of Florida.

Tramatic Injury: The Chief of Personnel said that the percent of Tramatic Injury has increased slightly during the past year. For the month of June, 1981, 12 out of 44 injuries were disabling.

The Chief of Nursing Service was very verbal regarding the possible Tramatic Injury (TI) abuses in her service. She said about 90 percent were back injuries, some of them re-injuries. She is trying to eliminate the TI and sick-leave abuse. Termination of an employee is "close to impossible", and while they are out of work, their positions cannot be filled thereby decreasing the numbers of an already short staff.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

Admissions Section: Visits through August 24, 1981, were 70,051. Planned through the month totaled 69,770. It is estimated that by the end of FY 81 visits will be 3,000 over the planned.

The 10 physicians assigned to this area are dispersed as follows: 5 to the "front line", 3 on nights (16 hour shifts), 1 HBHC, and 1 Chief.

The triage and vital areas are always staffed by a registered nurse (RN), but on evening and night shifts there is a skeleton staff. On evenings there is one RN and one LPN. On nights there is one RN and she has to cover the entire admissions area and may have to escort the new admissions to the unit. On a busy shift this is very inadequate and could be a detriment to patient care. The Chief said that anywhere from 1 to 20 ambulances a day come to the emergency room. In extreme emergencies even non-veterans are treated.

Although the support services are not in the immediate area of the Admissions Section, the Chief said their response and turnaround time was excellent. An area he said was lacking was the access to a CAT Scanner. Many times a borderline patient has to be admitted for further testing that could be eliminated with a CAT test. The Chief said that when the new hospital opens there is supposed to be one included with the new equipment.

One of the biggest problems in this area is the security. Many patients with weapons come into the Admissions Section. Most cases are not as disconcerting as the incident described earlier, but the potential is there. Many times people who have had too much to drink come in and cause a disturbance. An occurrence such as this could be dangerous during an emergency situation. It has been suggested that security station an officer in the admitting area, but their staffing is too low to accommodate this area regularly.

Ambulatory Care Clinic, St. Petersburg: This is the Clinic of Jurisdiction in the State of Florida. In FY 80, there were 73,116 outpatient visits. As of July, 1981, 62,051 visits had been accumulated, with 40 percent being service-connected (SC).

The Ambulatory Care Clinic (ACC) currently occupies two and a half floors of the Federal Building in downtown St. Petersburg. Plans to move the clinic to the first floor of the new hospital at Bay Pines commences on November 11, 1981. The reason given for this relocation was that approximately 70 percent of the veterans using this clinic travel past Bay Pines first.

One of the main problem at this Clinic is caused by the large influx of veterans into Florida. According to Regional Office (RO) records over 5,000 veterans a month are moving to this state, but that figure does not count the veterans who have moved to Florida and have not brought their records. Many complaints arise when a non-service-connected (NSC) veteran, who has been treated regularly at a northern hospital, cannot obtain the same treatment here. It was noted that the St. Petersburg area was not unique with this problem. The complaints have been rising steadily in all of southern Florida VA facilities.

This Clinic is also responsible for the largest Fee Basis Program (FBP) in the VA system. An estimated 175,000 visits are realized a year. All of the state, but 10 counties in the Miami area, are covered by this program at a cost of between 17-18 million dollars a year.

The staffing for this program has never been funded by VACO. The money comes from the Bay Pines budget.

The FBP grew so quickly that it ran unchecked for a number of years. In October, 1979, controls were placed on the program. The 32,000 FBP cards were trimmed to 22,000 when the veterans within a 40 mile radius of St. Petersburg, who could reach the Clinic with minimal difficulty, had their cards taken in. Better treatment planning and records are being kept by the FBP doctors and the number of prescriptions issued has

been reduced. This also included the use of oxygen at homes and nursing homes that was never discontinued on patients who may have no longer needed it. The Average Daily Census (ADC) in private hospitals was reduced from 80 to 30 and the Average Length of Stay (ALOS) dropped from 10 days to 4 days. The veterans are moved to the VA hospitals when able,but in a more timely manner.

Thirty-four thousand letters were mailed out to veterans explaining the FBP and their areas of eligibility. This was done in hopes of reducing the number of unauthorized claims (average 90 a week-60% private hospital bills).

Outpatient Clinic, Fort Myers: In January, 1981, this Outpatient Clinic (OPC) came under the jurisdiction of the Bay Pines VAMC from the Tampa VA Hospital. During the first six months, 1,600 phone calls were received by the Bay Pines Admission Section from Fort Myers. Each month 50-100 referrals for admission and consults are realized. The Clinic was originally built for 25,000 visits, but in the near future it is estimated that the growing population will dwarf this number. In FY 80 the total visits were 22,867. As of July, 1981, the visits totalled 15,419.

MEDICAL ADMINISTRATION SERVICE

The Chief of Medical Administration Service (MAS) said he has an excellent working staff, but currently there are 11 vacancies. He said he was short of ward clerks with minimal coverage in all areas. The evening shift has only three persons and the night shift has none. Between October and March of FY 81, the overtime amounted to $26,048.00.

The total hospital beds is 673 and they are distributed as follows:

Medical	363
Surgical	151
Psychiatry	128
Rehabilitation Medicine	31

(There are also 200 Domiciliary beds and 240 NHCU beds)

The Average Daily Census (ADC) for FY 81 through August 24 was 573 and the occupancy rate was 85.7%. On August 24 there were 19 veterans scheduled for admission (6 SC; 13 NSC) and 255 summaries pending. The Chief said most of these will be finalized within 10 days.

Except for pulmonary and admission for observation, all Compensation and Pension (C&P) exams are done at the ACC in St. Petersburg. None of the uncompleted 2501 exams are over 6 months.

The acceptance rate of Applications for Medical Care (VA Form 10-10) was 85%.

File space is very inadequate. The Chief said that VACO has approved the addition of a trailer next to the present file room to help alleviate the problem. Some of the inactive files are currently stored in the attic. He went on to say that the file space in the new building is going to be small, but if the renovation of the old buildings goes as planned there will be sufficient room.

An Admission Processing Time Study conducted from June 4 through June 10, 1981 provided the following information:

Normal Hours

	SC	NSC
Admissions Without Consults	62 minutes	54 minutes
Admissions With Consults	203 minutes	152 minutes

Irregular Hours

SC & NSC = 34 minutes

BED SERVICES

Medical Service: This service is responsible for 363 beds. They are are allocated as follows:

General Medicine	201
Female	12
Intermediate	138
MICU	8
CCU	4

The acting Chief of Medicine said that the space for this service was poor, but will be increased when the new hospital is opened. The equipment will be of the highest quality.

The acting Chief feels that a CAT Scanner is a much needed piece of equipment for improved patient care. With the aging veterans many of the old procedures that a CAT Scan replaces could be a detriment to a veteran if they have to be done.

A problem that the acting Chief said they are attempting to alleviate is the transfer of patients from community hospitals before they are stable. Also, many times when a patient is found out to be a veteran, he is brought to Bay Pines bypassing many private hospitals. Better communications with the private sector should relieve this problem.

The support from lab and x-ray was described as "superb".

Surgical Service: The beds in this service total 151 and are dispersed as follows:

Surgical	68
Urology	27
Orthopedic	34
Head and Neck	8
Eye	6
SICU	8
*Recovery	6

*Temporary beds that are not included in the total

The staffing for this service was described as adequate, but the Chief felt an additional anesthesiologist would be helpful. A request has been sent to the Planning Management Board for this position.

The space was described as barely adequate in the operating rooms (OR), but the Chief said all space will be enhanced when the new hospital opens. Although this service will lose 1 bed the SICU will be increased by 1, the recovery room will add 8

beds with 3 or 4 set up for isolation, and the OR and cystoscopy rooms will both increase by two.

All types of surgery except open heart, neurosurgery, penal implants, and sophisticated plastic surgery are done at this Medical Center. When the new facility opens neurosurgery may be added.

There is currently a two and a half month backlog for minor surgery. Most of the procedures are in orthopedics. These patients are being carried on Pre-Bed Care (PBC).

The Chief feels that with the modern equipment being installed in the new hospital this facility could become a good training center for an affiliation.

Major surgical procedures done in FY 80 totalled 2,021 and total minor procedures were 968.

Psychiatry Service: The 128 beds in this service are distributed as follows:

Acute Psychiatry	78
Alcohol Treatment Unit	30
Combat Treatment Unit	20

The Coordinator of the Acute Psychiatric Units (APU) feels the staffing for the type of care given at this facility is sufficient, but that the space is barely adequate and needs to be improved. After the renovation of Building #1 this service will total 150 beds and will occupy the top four floors, but not until 1985.

There are approximately 60 admissions a month and the Average Length Of Stay (ALOS) is 18 days. Some of the older and sicker patients average longer stays because of placement problems. The coordinator feels that a Geriatric Psychiatric Unit may be needed in the near future. He also feels that a full-time social worker for these units would be of great assistance in helping relieve the time consuming problems realized in psychiatric placements.

The types of therapies used in this service are: group therapy, psychotherapy, chemotherapy, physical therapy (PT), occupational therapy (OT), recreational therapy (RT), and correctional therapy (CT). Because of a hospital wide staff shortage, these patient treatments are not utilized to their fullest extent.

The two units for the acute care patients were locked before the present Chief of Psychiatry took over. During that time it was related that 36 "incidents" occurred during a two month period. (An incident was described as being the seclusion and/or the restraining of an out of control patient). After the units were unlocked this number dropped to three. There were 44 elopements during one quarter, but attempts to reduce this problem are being made through the use of peer pressure by the patients.

One of the main follow-ups after a patient's discharge is a re-entry group that is operated by The American Legion, Post #14. Between 60-80 veterans are in the program and they meet 2 to 3 times a week. The main theme is to learn how to get back into community living.

Alcohol Dependence Treatment Unit (ADTU): The ADTU was established in 1972 through special funding from VACO. The Chief of ADTU feels he has a good program with the alloted staff, but it could be much better with the proper staffing. The

Chief said the staffing should be 15 augmented and 17 core. The 17 total full-time staff for this 30 bed unit are:

Administrative:

1 Chief (Psychologist)
1 Secretary
1 Medical Clerk

Non-Administrative:

1 Psychiatrist
1 Clinical Psychologist
1 Counseling Psychologist
2 Clinical Social Workers
1 Alcohol Rehabilitation Counselor
8 Registered Nurses (RN)

The full-time staff is complimented by the following part-time employees:

0.5 Nurse
0.5 Recreational Therapist
0.1 Corrective Therapist
0.1 Occupational Therapist

One staff member has been a non-drinking alcoholic for seven years. An additional RN position was denied, but no answer has been received regarding an alcohol counselor for ambulatory care.

The program length is 30 days with an average 8 week waiting list. When a veteran first applies for admittance to the program, he is screened to establish his motivation to quit drinking. He is then either admitted to a medical unit for detoxification or placed on ambulatory PBC. If it is felt that a patient is unable to handle PBC alone, he can be placed into the Pinellas County detoxification program. The criteria while on PBC is a weekly group meeting and other treatments and activities as prescribed for each patient.

After admission to the unit a full daily schedule is started and includes the following: educational classes, medical treatment, group and individual counseling, relaxation groups, assertiveness training, marriage, couples and family counseling, and AA meetings. Antabuse is used but not required unless a client is a repeater.

The readmission policy is liberal, if the motivation factor is still present. If someone returns twice within a years time, he is tried on a two week refresher course. Two admissions in a three month period is discouraged unless it is before someone has started to drink. It is felt that it is more cost effective to supply early support for a short period rather than wait and have someone readmitted for the full program.

The patient government makes the rules for the unit. No weekend passes are allowed the first week, but day passes are used when it is necessary (e.g. court dates). Urine tests are given if drug use is suspected and a breathalyzer is used upon return from passes. Drinking while in the program is grounds for immediate dismissal.

A one year patient follow-up program is used after discharge. During our visit 49 individuals and 7 couples were being monitored. Between 95-110 phone contacts are made each month and letters and questionnaires for research purposes are mailed out every three months.

A Halfway House (HWH) in St. Petersburg is used for aftercare treatment and will be discussed later in this report.

Vietnam Combat Veteran Rehabilitation Unit (VCVRU): This 20 bed unit was opened in May, 1981 to help Vietnam combat veterans deal with the atrocities of the war, their anger, frustration, and guilt, the indiffernce by others, and the "Delay Syndrome" experienced by many. Most veterans prior to the opening of this unit were discharged from other psychiatric programs with diagnoses of character and behavior disorders because their problems were unique to most treatment plans.

The objective of the program is to enable the veteran to function in the community at a level that is personally satisfying, productive, and relatively free of the symptoms that have been disabling him since his return from Vietnam.

Referrals for this program comes from the Vet Center in St. Petersburg and word of mouth. The Vet Center and the Combat Unit have a liaison representative. There is a good rapport between the two programs with an interchange of patients to attend meetings at both facilities when it is deemed necessary to enhance the veteran's treatment.

Because the unit is so new the staff meets every 8 weeks for an internal review of the program and its objectives. A follow-up program has not been structured yet, but a schedule of return visits at 6 weeks, 6 months, and 1 year is being planned.

Statistics regarding the ALOS, success rate, staff burnout, et.al., has not been formulated. Forty members have finished the program.

Intensive psychotherapy groups are held five days a week. Other groups held once or twice a week are: Significant Others (wives, family, girlfriends), Drug and Alcohol, Problem Solving, VA Benefits,and community meetings attended by the entire unit.

Prescriptions (except for medical problems) and self-medications are discontinued after the first few days of the program because it has not proven to be an effective means of handling their problems. Periodic drug screens are a prerequisite agreement to being in the treatment program.

Specific staffing needs for this area were full-time positions in: social work, corrective therapy and recreation. The Coordinator said recreation activities for the weekend were insufficient for this area. These veterans have alot of intense feelings and energy that needs to be directed and released in an appropriate manner to retain good treatment continuity.

Two nursing personnel are Vietnam combat veterans.

Mental Hygiene Clinic: The Coordinator of this program said that the approximately 9,000 visits realized in FY 80 would probably triple next year with the move of the downtown clinic to Bay Pines, commencing this October 13th.

In FY 80, there were 490 admissions to the program and 510 discharges. There currently are 400 patients being treated at the Bay Pines Clinic.

97-259 O—82——5

When a new applicant applies or is referred to the program from psychiatry, he is put in a therapy session within two weeks. The treatment is short term and intensive and consists mainly of groups. The community re-entry program is also used.

Whenever it is considered necessary, a client can be referred for inpatient care. Dietetics is also consulted when it is noted that a patient is not receiving proper nutrition.

Halfway House (HWH): Opportunity House is just one of many services affiliated with the Pinellas Comprehensive Alcohol Service, Inc. This non-profit organization receives $17.00 a day from the VA. Their break even cost is $20.00 a day.

The one story building sits on 10 acres and can handle 85 clients. The HWH service controls 25 beds that can accommodate females and is wheelchair accessible. Currently, nine veterans are living here with three of them working in the kitchen and maintenance. Fifty-six veterans have completed the program.

If a client is not discharged for drinking, his stay is 60 days, but it will be extended if the need arises. A minimum of 5 AA meetings a week is mandatory. They are held on and off the grounds,but clients are encouraged to attend the community meetings to help him ease back into society. An 11:00 p.m. curfew is enforced Sunday through Thursday and a 1:00 a.m. curfew on Friday and Saturday. Two washers and dryers may be utilized at any time.

Recreational activities include weight lifting, cookouts, volleyball, softball, fishing, and soccer and football games in Tampa.

Assistance is given to those who are seeking employment,but the leg work is done by the clients.

During our visit to the facility, renovations and repairs were in full swing preparing for their first JCAH inspection.

Rehabilitation Medicine Service (RMS): The Chief of this 31 bed service feels that with an increase of 4.4 full-time employee equivalent (FTEE) and a full-time physician to operate the electromyography (EMG) equipment, he could get all his programs started. There are currently two vacancies in RMS. The position for CT is about to be filled, but the PT opening is much more difficult because the private sector pays better.

The only therapies provided by this facility are CT, OT, and PT. Visits to these areas in FY 80 were: CT-42,024, OT-23,582, and PT-33,631. Bedside care to other services is provided,but because of a shortage of staff, it is minimal. Driver training is referred to the Tampa VA Hospital.

Equipment for this service was described as good and is replaced as needed.

NURSING HOME CARE UNIT

The first 120 bed, one story building opened in April, 1973. It's mirror image was opened in November 1980 with a large dining facility between the two to service patients in both buildings.

The Supervisor of the NHCU feels that the regular staff is adequate at present, but some of the support services need increased staffing to meet the growing demands.

The greatest needs are in Recreation and Occupational Therapy. A therapist for Activities of Daily Living (ADL) training is also evident. The nursing staff currently provides this service.

The ADC is 180, but this will increase when the expected 95% occupancy occurs. Thirty of the 64 veterans on the waiting list are scheduled for admission in September, 1981. The ALOS is 2½ months.

The space is excellent. Most of the rooms contain two beds. All areas are large enough to handle the 65% of the population who are in wheelchairs.

The Chief of Staff said 8 physicians rotate through the nursing home on a regular basis. Two are assigned to the day shift with an on call service provided for evenings and nights.

The oldest veteran is 107 and the youngest is 21. The average patient age is 75.

On the day of our visit the patients in Category I-IV (with I needing the most care) were:

Category I	77
Category II	46
Category III	47
Category IV	8

Safety and fire features were of a high caliber. Sprinkler and smoke detectors were in all patient areas and there were numerous exists. Regular fire drills are held for staff and patient education of evacuation procedures.

DOMICILIARY

According to the Director, 30 hospital staff positions were eliminated when the new 200 bed Domiciliary was opened in February 1981. The reason for this was the bed reduction from the old Domiciliary by 122. Although this may be a standard staff to patient ratio it should be noted that members of a Domiciliary need less total care than bed patients. The staff reduction added to the already low core ratio for a hospital of this magnitude.

A number of nagging problems have plagued this new facility, but we were told the contractor was in the process of rectifying them. The two most easily noticed were leaks in the roof and the dripping condensation from the air-conditioning ducts.

The one story building consists of four wings and a central core for administration and 180 seat cafeteria.

Smoking is allowed only in five lounges because this is a "fresh air" building. Each lounge contains a non-functioning smoke eater but we were assured that they all would be hooked up in the near future.

Each wing, which can handle both male and female veterans, has six private and 22 semi-private rooms. There are also two small apartments with complete kitchens in each section used by veterans just prior to their re-entry into the community.

All Domiciliary members are required to go through a smoking clinic, a nutrition program, and an alcohol awareness program. Although all veterans may not need one of

these programs, they can learn how a problem affects someone else or voice their feelings as to how it may affect them.

The ADC is 177. The average age of the veterans is 54 with the youngest being 23 and the oldest 80. The 9 wheelchair members are totally independent.

All hospital therapies are available here,but the Domiciliary Industries Program is run by the Chief of the Domiciliary because of the shortages of staff in RMS. In the Industry Program veterans learn printing, engraving, and graphic arts. A dark room will be available soon for film developing.

MEDICAL SUPPORTIVE SERVICES

Audiology and Speech Pathology (A&SP): The Chief of A&SP said his service has been in the same location since it was established in July, 1966. The first move will be to the first floor of the new hospital near ambulatory care. The Chief said his space will double and the new improved equipment will enhance veteran care.

This service has three full-time Speech Pathologists, 3 full-time Audiologists (2 are in the St. Petersburg Clinic), a Speech Pathologist Health Tech, and 1 Secretary. A request has gone to VACO to increase the staffing when the new hospital is opened.

The 3 sound testing booths (hospital-1, downtown clinic-2) will be increased by 1 at the new location.

In FY 80, 613 hearing aids were dispensed. It is estimated that over 800 will be dispensed in FY 81. The hearing aids are ordered through prosthetics. The Chief said he gets good cooperation and service from them.

New programs for this service are difficult to start because of staffing. One new unfunded program is Tinnitus or ear noises. It is estimated that 36,000,000 Americans suffer from this affliction. There are a number of treatment techniques used but the one most responsive when tested at this facility is relaxation training through the use of biofeedback.

The catchment area for this service is 10 counties north and south of Bay Pines. Some are shared with the Tampa VA Hospital. They also maintain the entire state of Florida in the fee basis program.

The Chief said that a visit by a SERP team last February, 1981, gave his service an excellent rating.

Pharmacy Service: The Chief of Pharmacy said that a major problem facing his service is the lack of computerization. A computer system is due for this service in FY 83 after the move into the new hospital. The computer equipment should be installed prior to the pharmacy's transfer to prevent the disruption of the service and to save additional time and money that will be realized once the service is operational.

This very busy pharmacy has three outlets: the hospital, the ACC in St. Petersburg, and the OPC at Fort Meyers. The window services at all three locations are open 8-4:30 Monday through Friday. A total of 350 outpatient prescriptions are filled a day. It is estimated that all three pharmacies will fill 780,000 prescriptions in FY 81.

The largest pharmacy is located at the ACC in St. Petersburg and handles all the mailouts. An average of 1,900 prescriptions are mailed daily with a 3-4 day turnaround.

Unit Dose will be included with the new hospital package. An Intravenous (IV) Additive Program and a Hyperalimentation Program have been in use for over two and a half years, the latter not being funded by VACO. Two staff are assigned to prepare the mixtures five and half days a week. Eight to twelve are done a day and they take about 30 minutes to prepare.

The Chief said that volunteers are used to file and pre-package medications. He went on to say that his service would "die without them". Because of his lack of staff,patient consultations are minimal.

A Drug Abuse Review Board was established at the downtown facility to oversee the entire Fee Basis Program. A $400,000.00 savings was achieved through their efforts. Much of this was saved through the reduction of the "poly" pharmacy veterans who were taking more medications than necessary.

Nursing Service: The Chief of Nursing Service said she needed an increase of 200 personnel in her ceiling to adequately cover all patient care areas. The long term care units are running at 50 percent staffing and the specialty care units coverage is very inadequate. During the week of August 24, 1981, the SICU was short 5 staff and the MICU and CCU were each 2 positions short. None of these units has had to be closed because non-professional staff are being used in place of registered nurses (RN's). This is against JCAH regulations. Many times an RN will have to leave these intensive care units when a Code Blue (call for assistance heart attack victim) is called in another part of the hospital. This is very detrimental to veteran care and needs to be rectified by VACO.

There is no shortage of nurses in this area, just positions to put them in. The Chief of Nursing said that 300-500 applications are on file at any one time. Even then, when there is an opening she is not always able to get the caliber of nurse she needs because the VA is not competitive with the community salaries.

The Chief said she is having a serious problem with traumatic injury and sick-leave abuses. A number of steps have been taken to relieve the problem, but it is difficult when you are allowed 45 days off with pay for a work related injury. She added that 90% of the staff out on extended leave were due to "back injuries".

Other staff shortages in the hospital have a direct effect on this service. A shortage of ward clerks takes nursing care from the veterans when nurses are answering phones, etc. The same is true when building management is unable to provide someone to wash beds after patients are discharged. Some admissions have been held up as long as 3 hours because a room was not ready for them.

Overtime for FY 80 totalled $37,458.00. As of July 31 of FY 81 the total was $53,175.00. Without additional help this figure will continue to grow.

While touring the bed care units it was noted by this writer that the new hospital will come none too soon. Ward storage was non-existent Wheelchairs, stretchers,et.al. were stored on screened porches but were exposed to the salt spray. These porches also doubled as patient and staff lounges. Linen storage many times was in the hallways.

Nursing stations were not always in view of the patient care areas and the

ward clerk desk often was nowhere near the nurse's station.

Outside the SICU is a 12 bed unit that used to contain minimum care patients. The SICU staff could make occasional checks on them. Currently, sicker patients are being admitted there but the SICU staff has remained the same. One incident, during the night of August 24, 1981, in which one of those patients became confused, got up and fell, required overtime to handle the follow-up. This is not only a burden on the SICU staff, but very dangerous to the SICU patients.

Oxygen is not piped into patient areas so large containers have to be brought to bedsides when they are needed. Often nursing personnel have to leave their units to obtain a key in a different building to get oxygen locked in another building. This again takes away from much needed patient care.

Social Work Service: The acting Chief of Social Work said he had 26 Master Social Workers (MSW) and 3 Social Worker Associates (SWA). One vacant Supervisor's position is to be filled soon. Two SWA's split their time on the wards to canvass patients to be released and aid with their discharge planning. The third is stationed in the Admission Area to help with referrals for NSC veterans. During the first 10 months of FY 81, 1,947 referrals were made and distributed as follows:

VA Resources	1,074
State Government Resources	374
Non-Government Resources	499

The only referral difficulty is in the area of dental care.

The Residential Home Care (RHC) Program is in the fledgling stage. The assigned MSW splits his time with the NHCU. One home has just been approved and three are pending. Homes have to meet state certification (takes 60 days) and then are inspected by the VA. Presently, there is one psychiatric patient ready to be placed in the home.

One MSW is assigned to the 50 patient Hospital Based Home CAre (HBHC). Patients are usually followed for six months unless they are terminally ill. Then they are followed as long as needed. These patients account for 33% of the veterans in the program.

Four MSW are alloted to the community nursing homes. There are 33 homes available and at the time of our visit there were 183 veterans out on contract.

Space for this service was described as good since their move to new quarters the week before.

ANCILLARY SERVICES

Dietetic Service: Although this service is just 4 part-time positions short of being at ceiling, filling them will not provide adequate coverage for all areas. The ceiling needs to be raised,but with the cloud of OMB A-76 hovering over their heads, this cannot be done. The Chief said her staff morale is still good and feels that the ramifications of A-76 have not sunk in yet.

Building #36 is just dietetics and includes a dining room used for psychiatric patients and volunteers. The pellet system is used to transport food to the bedside. The Domiciliary and NHCU have their own kitchens and most of their food is prepared in the main kitchen and trucked over. Grills at these two facilities provide fast

food cooking and breakfast meals. There is a separate dining area in each for the residents.

Modified diets served and the amount of convenience foods used are both at 50%. The Chief said that she had a good patient education program regarding their diets.

An average of 933 patients are served three meals a day at a raw ration cost of $3.34.

Office and freezer space were both described as being tight and should improve when this service moves to the new hospital. New equipment will also be used. Self directed module carts are suppose to improve service,but this type of operation has been plagued by problems in the past.

After talking with patients and eating a meal myself, the food at this facility can only be described as excellent.

Veterans Administration Voluntary Service (VAVS): The Chief of VAVS said he runs a "dual program". In the winter "Snow Birds" compliment the regular volunteers and in the summer the youth program is used.

Approximately 1,200 volunteers from 38 organizations have contribued over 200,000 hours so far this fiscal year. The Chief said 35 hospital services utilize the volunteers.

The American Legion representative is Mr. Eugene Egg and his deputies are Miss Margaret L. Kumpf and Mr. Walter H. Oosterling. In FY 80 the 95 regularly scheduled volunteers contributed 12,000 hours.

The representative for the American Legion Auxiliary is Mrs. Barbara Pfohl. Her deputies are Mrs. Patricia Moore and Mrs. Edna Locke. (Mrs. Locke has been a volunteer at Bay Pines since 1948 and has contributed over 35,000 hours). The 95 Auxiliary volunteers have been averaging 950 hours per month in FY 81.

The American Legion and Auxiliary work very closely together. Organizing picnics and making The American Legion Poppy are just a couple of activites they direct.

The Summer Youth Program has been so successful that they are reaching a saturation point. This past summer 168 youths contributed 12,000 hours. The return rate for these volunteers is 40%. Each year at summer's end a Youth Volunteer Recognition Ceremony is held. This year a picnic was organized and awards were distributed.

The Chief of VAVS is very pleased with the additional space this service received when they moved to Building #2 three months ago. He also said that the only staff shortage was a secretary. He has made three requests,but hospital wide priorities are the reason for this empty position.

The only other problem noted was a break-in in which canteen books were stolen, but the three culprits were caught by security.

Recreation: The Chief of Recreation said to run a full program she would need four more full-time therapists. She said there were no full-time therapists for the following units: Intermediate, ATU, Psychiatry, and Vietnam Combat. Currently, the patient work load per therapist is 350. The only vacancy she is recruiting for is a part-time bus driver.

The hours of operation are from 6:30 a.m. to 10:00 p.m. six days a week and 12:30 p.m. until 9:00 p.m. on Sundays.

The Chief said that Volunteer Service is "fantastic". Between 150-200 members give their time each month although many are limited in their activities because of their age.

One unique aspect of this service is the availability of an Artist in Residence who is being paid by the National Endowment of Arts in Washington, D.C.

III. CONCLUSION

The exiguous and dedicated staff at this VAMC are providing patients the best possible care under the circumstances. It could be improved greatly with the proper amount of staff. The hospital core ratio of 1.47 is inadequate for this non-affiliated facility. Veteran care is definitely being compromised.

A CAT (head) Scanner is a piece of equipment that is urgently needed. The transportation of veterans six miles to and from the contracted facility is not only costly, but an endangerment to the veteran's health.

The pharmacy needs to be computerized as soon as possible. To save time and money this should be accomplished before the service moves into the area provided in the new hospital.

The fear of OMB A-76 is upper most in many hospital employees' thoughts. The uncertainty of their jobs in the future is taking away from the dedication to their duties. The laundry personnel are currently feeling this firsthand while the laundry is undergoing renovation.

Better security is a must. The surveillant and communication system planned for installation in the new facility and grounds area will enhance the safety of staff, patients, and visitors.

The shortcomings on the patient units regarding space and inadequate placement of nursing stations should be eliminated with the opening of the new building. The new equipment will provide the staff with increased techniques to treat our veterans.

Renovation of the old buildings is a major step to prepare for the future. With the increasing number of veterans moving to Florida, the ability to expand readily will decrease the chance of major obstacles.

IV. RECOMMENDATIONS

1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize a significant increase in the FTEE ceiling and funding at VAMC Bay Pines.

2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support the acquisition of a CAT (head) Scanner for the new hospital at VAMC Bay Pines.

3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support the funding of the computerization of the Pharmacy at the new hospital before it is put into operation.

4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support the funding needed to install the security cameras and communication system in the new hospital.

5. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support the return of laundry control to the VA after the renovation is completed.

6. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue supporting the total renovation of the existing buildings at VAMC Bay Pines.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION (HOSPITAL ONLY) BAY PINES, FL DATE OF INFORMATION 8-17-81

MEDICAL CENTER DIRECTOR RICHARD F. McELLIGOTT

ASSISTANT MEDICAL CENTER DIRECTOR L. W. WALKUP

CHIEF OF STAFF HENRY F. BURKE M.D.

MEDICAL SCHOOL AFFILIATION

	(as of Jul.) CURRENT FY 19 81	LAST FY 19 80
BED CAPACITY	673	673
OPERATING BEDS	673	673
AVERAGE DAILY INPATIENT CENSUS	572	600
STAFF OUTPATIENT VISIT (ACCUM.)	65,632	81,131
WAITING LIST: SERVICE-CONNECTED	Ø	Ø
NONSERVICE-CONNECTED	Ø	Ø

EXPLAIN THE REASON FOR THE WAITING LIST:

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 23,765

NUMBER OF APPLICATIONS ACCEPTED 17,705

NUMBER OF APPLICATIONS REJECTED 6060

APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR 21,199

NUMBER OF APPLICATIONS ACCEPTED 16,724

NUMBER OF APPLICATIONS REJECTED 4,475

CENTER

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1691.7

CORE RATIO 1.47 as of 7/12/81

STAFF PHYSICIANS (FTE) 99

CONSULTANTS ON THE ROLLS 72

ATTENDINGS ON THE ROLLS 2

RESIDENTS None

MEDICAL STUDENTS None

PHYSICIAN EXTENDERS 2

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) 1-Internal Medicine; 1-Cardiology

REGISTERED NURSES 40

LICENSED PRACTICAL NURSES 20

NURSING ASSISTANTS 20

OTHERS 1 - Physical Therapist, 1-Clinical Psychologist, 1-Neuropsychologist
1 - Geronrological Psychologist, Engineering-12 full time
These are the most critical at this time

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 6

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 13

SUMMARIES PENDING 255

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE 2501

OPERATING BEDS IN NURSING HOME CARE UNITS 240

FUNDS

AVERAGE COST PER PATIENT DAY $121.60

AVERAGE COST PER OUTPATIENT VISIT $27.96

AVERAGE COST PER NHCU DAY .01 $86.96 @ Day

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES $39.29

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) FY-81 - 74,079,561(7/31/

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) FY-80 - 61,969,100

VA DOMICILIARY STATISTICAL REPORT

LOCATION BAY PINES, FL DATE OF INFORMATION 8/17/81

DOMICILIARY CHIEF John A. Benson

ASSISTANT DOMICILIARY CHIEF John R. Sherman

CHIEF OF STAFF Henry F. Burke, M.D.

	(as of July FY 81) CURRENT FY 1981	LAST FY 1980
BED CAPACITY	200	215
BEDS IN OPERATION	200	215*
AVERAGE DAILY		
INMEMBER CENSUS	172	240
OUTMEMBER CENSUS (EOM) A.S.I.H.	8	6
(A.A./U.A. EOM)	11	6
NUMBER OF SERVICE-CONNECTED	62	NA
NONSERVICE-CONNECTED (Number of members in Dom as of 8/13/81)	115	NA
WAITING LIST: **		
SERVICE-CONNECTED	ø	12
NONSERVICE-CONNECTED	ø	35

EXPLAIN THE REASON FOR THE WAITING LIST:

**Waiting list in FY 80 due to construction on new Domiciliary and reduction in operation beds. (*Operating beds for FY 80 for first 3 qtrs. was 322, reduced to 215 for 4th qtr. Average number of operating beds for FY 80 was 295.)

APPLICATION FOR DOMICILIARY CARE RECEIVED THIS FISCAL YEAR 298

NUMBER OF APPLICATION ACCEPTED 193

NUMBER OF APPLICATION NOT ACCEPTED 105

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED)

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED)

FUNDS

AVERAGE COST PER MEMBER DAY $64.71

DOMICILIARY_

FUNDS (CONTINUED)

AVERAGE COST PER MEMBER DAY IN A SIMILAR COMMUNITY FACILITY $64.71

DOMICILIARY BUDGET ALLOCATION (THIS FISCAL YEAR) $2,169,539 (FY-81 Annual Plan)

DOMICILIARY BUDGET ALLOCATION (LAST FISCAL YEAR) $3,371,073 (FY-80 Annual Plan)

STAFF

TOTAL DOMICILIARY PERSONNEL (FTEE) 11

CORE RATIO .06 as of 7/12/81

STAFF PHYSICIANS (FTE) .4

CONSULTANTS ON THE ROLLS 0

MAJOR PERSONNEL SHORTAGES

REGISTERED NURSES 10

LICENSED PRACTICAL NURSES 0

NURSING ASSISTANTS 0

OTHERS-ALL CATEGORIES:

Domiciliary - 1 (Administrative Full Time)

Dietetics - 4 (Full Time)

Building Management - 6 (Full Time)

Engineering - ? (1 Air Cond., 1 Ground Labor, 1 Repairman) (Full Time)

ehabilitation Medicine - 4 (Full Time) 1-C.T., 1-O.T., 1-VRT, 1-Education)

Psychology - 1 (Full Time) Psychologist

Social Work Service - 1 (Full Time Social Worker)

NEED - 30 FTEE

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION AMBULATORY CARE CLINIC, ST. PETE FL. DATE OF INFORMATION 8-17-81

MEDICAL CENTER DIRECTOR RICHARD F. McELLIGOTT

ASSISTANT MEDICAL CENTER DIRECTOR L. W. WALKUP

CHIEF OF STAFF HENRY F. BURKE M.D.

MEDICAL SCHOOL AFFILIATION

	(as of July) CURRENT FY 19 81	LAST FY 19 80
BED CAPACITY		
OPERATING BEDS		
AVERAGE DAILY INPATIENT CENSUS		
STAFF OUTPATIENT VISIT (ACCUM.)	62,051	73,116
WAITING LIST: SERVICE-CONNECTED		
NONSERVICE-CONNECTED		

EXPLAIN THE REASON FOR THE WAITING LIST:

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 4523

NUMBER OF APPLICATIONS ACCEPTED 3823

NUMBER OF APPLICATIONS REJECTED 700

APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR 3015

NUMBER OF APPLICATIONS ACCEPTED 2564

NUMBER OF APPLICATIONS REJECTED 451

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION OUTPATIENT CLINIC, FT. MYERS, FL. DATE OF INFORMATION 8-17-81

MEDICAL CENTER DIRECTOR RICHARD F. McELLIGOTT

ASSISTANT MEDICAL CENTER DIRECTOR L. W. WALKUP

CHIEF OF STAFF HENRY F. BURKE M.D.

MEDICAL SCHOOL AFFILIATION _____

	(as of July) CURRENT FY 19 81	LAST FY 19 80
BED CAPACITY		
OPERATING BEDS		
AVERAGE DAILY INPATIENT CENSUS		
STAFF OUTPATIENT VISIT (ACCUM.)	15,419	22,867
WAITING LIST: SERVICE-CONNECTED		
NONSERVICE-CONNECTED		

EXPLAIN THE REASON FOR THE WAITING LIST:

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 9058

NUMBER OF APPLICATIONS ACCEPTED 4573

NUMBER OF APPLICATIONS REJECTED 4485

APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR 7597

NUMBER OF APPLICATIONS ACCEPTED 5916

NUMBER OF APPLICATIONS REJECTED 1681

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
VETERANS ADMINISTRATION MEDICAL CENTER
MIAMI, FLORIDA

I. INTRODUCTION

During the period of August 24-28, 1981 a regularly scheduled visitation was conducted to evaluate the quality, quantity, and timeliness of health care provided to veterans.

Coordination: Notifications of the planned visit were forwarded to Mr. Thomas C. Doherty, Medical Center Director, and to Messrs. Dyke E. Shannon and Robert R. Erskine, Department Adjutant and Department Service Officer respectively. In addition, Mr. David H. Pechenik, VAVS Representative, The American Legion, Department of Florida, was notified.

Statistical information pertaining to the personnel strength, patients on the rolls, and operating costs is attached.

Professional Affiliation: The Medical Center's primary affiliation is with the University of Miami School of Medicine. In addition, the Medical Center is affiliated with the University of Florida School of Dentistry and has residency training programs in General Practice Dentistry, Endodontics, and Oral Surgery.

Hospital Accreditation: This facility was surveyed by the Joint Commission on Accreditation of Hospitals (JCAH) in December 1979. A two year accreditation for general medical and surgical was awarded. However, for the second consecutive survey, another 1 year accreditation for psychiatry and the alcohol and drug programs was received. The Director maintained that a full accreditation is expected during the next survey, scheduled for the end of this year.

MISSION OF MEDICAL CENTER

The Miami VAMC operates a full service (primary, secondary, and tertiary care) health care facility consisting of 736 operating beds, a 120 bed Nursing Home Care Unit, and a satellite outpatient clinic at Riviera Beach. Activation of another satellite outpatient clinic (Broward County) is scheduled for October 1, 1981.

Specialized Medical Programs provided are Alcohol Dependence, Drug Dependence (inpatient and outpatient), Cardiac Catheterization, Mental Hygiene Clinic, Electron Microscopy, Hemodialysis Center, Home Dialysis Unit, Hospital Based Home Care, Nuclear Medicine Unit, Prosthetic Treatment Center, Pulmonary Function Lab, Respiratory Care Center, Speech Pathology Unit, Spinal Cord Injury Center, and Supervoltage Therapy.

The 736 operating beds, and their bed occupancy rates through July 31, 1981, are designated as follows:

Medicine	235	71.9%
Intermediate	61	89.7%
Neurology	20	74.5%
Rehabilitation Medicine	20	90.0%
Spinal Cord Injury	35	61.4%

Surgery	208	65.6%
Psychiatry	*157*	*73.7%*
Total hospital	736	72.1%

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: According to the Director, funding and staffing for VAMC Miami have historically been inadequate. Consequently, this facility is unable to meet the demands of the 470,000 plus veterans in the immediate catchment area.

Numerous personnel throughout the survey expressed their concern over a recently implemented local policy pertaining to outpatient treatment for non-service-connected (NSC) veterans. To meet the budgeted work load, NSC veterans are only followed for 90 days and then dropped from the rolls. However, at the end of 90 day follow-up, the veteran's condition is re-evaluated by a physician. If additional follow-up care is deemed necessary, the veteran is admitted to the hospital for evaluation for 1 to 3 days, discharged, and allowed another 90 days follow-up care. It was reported that service-connected veterans are not affected by this policy.

One serious problem with this policy concerns drug and alcohol patients. Proper follow-up for these patients should be a minimum of one year. Consequently, after 90 days, the veterans are required to be readmitted to the ADDP ward, stay overnight and only then can they receive an additional 90 days. Many are refusing to be readmitted, therefore they are dropped from the rolls. Not only is this a disruption to the program, but one counselor stated that "the veterans feel that they are being blackmailed because they cannot receive outpatient treatment unless they are readmitted." Further expansion of this will follow under the Alcohol and Drug Treatment Program.

Actual outpatient visits have exceeded funded visits by more than 30,000 for several years. Exact costs for absorbing these additional visits could not be determined, but is expected to total about 1.5 million dollars per year. It was for this reason that this local policy was established. Discussions with management indicated that this policy is not permanent. Optimistic sources anticipate that the new satellite clinic in Broward County will relieve this outpatient clinic to a certain degree. Activation of this clinic, which was reported to be funded for 50,000 outpatient visits the first year, is expected before the end of this calendar year.

Construction of a Research and Educational Building is ongoing. Completion of this three story building is expected by June 1982. This building will ultimately provide much needed space within the hospital.

Another urgently needed project to provide space is scheduled to begin in 1983. This project is the Ambulatory Care Extension. Completion is targeted for late 1984, possibly early 1985.

Parking is still a horrendous problem for this facility. Ongoing construction projects have further aggravated this problem. Discussions between VA Central Office and management have identified the possibility of leasing space in the immediate area to be utilized for parking. Construction of a garage was reported to be out of the question.

A recently constructed Nursing Home Care Unit (NHCU), consisting of 120 beds, was built with the capability of adding 120 more beds in the future. Plans for doing just that have been approved and are expected to be implemented in FY 83. It is worth noting that only 90-100 beds are currently being utilized due to insufficient staff. Further discussion on this will follow under the NHCU section of this report.

Professional Services: According to the Chief of Staff, VAMC Miami is poorly funded and staffing is inconceivably low. The most glaring staffing shortcoming is Nursing Service.

The Chief of Staff expressed his concern pertaining to the underfunded outpatient programs and the need to reduce treatment to NSC veterans. It was stressed, however, that any veteran in need of immediate medical care receives treatment. When it becomes necessary to discontinue treatment for a NSC veteran, that veteran is counselled and assisted in locating community resources.

The professional staff was reported to be highly qualified. Approximately 90% are board certified.

Assistant Director: With the exception of Security Service, the Assistant Director feels that those services under his supervision are adequately staffed. Recruitment and retention of qualified security personnel is virtually impossible with the current pay grades. In an effort to improve security, VAMC Miami has requested a closed circuit television system. No response has been received from VA Central Office.

The Assistant Director discussed the demoralizing effect OMB Circular A-76 is having on many personnel. On station visits by local contractors, hoping to gain a working knowledge of the hospital, are a reality. The threat of the possible implementation of OMB Circular A-76 is starting to affect recruitment efforts.

Security Service: According to the Chief of Security, the current personnel ceiling of 19 FTE is inadequate. The Chief stated that 35 security personnel are needed to provide an acceptable level of security.

This facility is located in a high crime area. Security personnel are oftentimes responsible for providing escort service for hospital employees walking to their cars after dark. Additionally, because of the lack of sufficient parking areas, officers have to be assigned to traffic control duties.

As is the case with most Security Services in the VA system, turnover is high and recruitment and retention is difficult with the current pay structure.

Incidents requiring security intervention are numerous. During the survey, Miami police were called to arrest a woman waving a handgun at patients and visitors as they came into this VA facility. It was fortuntate that no one was physically injured.

Officers expressed their concern pertaining to the daily drug delivery to the outpatient drug unit located off station. Many feel it is only a matter of time before the two unarmed officers delivering these drugs are involved in a confrontation.

REGIONALIZATION

Through conversations with all levels of Medical Center management, it was discovered that an amicable relationship exists among member Medical Centers in Medical District #12. An overall distribution of problems and funds is realized. This Medical Center is located in the Southeastern Region.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

An initial orientation is received by new employees on their first day. This includes discussions pertaining to insurance, leave policies, salary information, and fringe benefits. Following this, new employees are orientated to their individual work sites and introduced to the staff and their co-workers.

Approximately one month after the new employee begins work, a follow-up procedure is performed by Personnel Service. This involves a question and answer session, guest lectures, a review of personnel procedures, and films.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

The ever increasing number of outpatient visits to this facility has caused management to limit treatment to non-service-connected (NSC) veterans. In an effort to alleviate the 30,000+ visits over budget, NSC patients are followed for a maximum of 90 days. Extensions to this 90 day limit can only be accomplished by readmitting the veteran for 1-3 days to reevaluate him/her. If further follow-up care is deemed necessary, the veteran can continue on outpatient status for another 90 days.

The Associate Chief of Staff for Ambulatory Care reported that he is satisfied with all aspects of his staff complement, except nursing.

The critical shortage of space within this service will be addressed with the proposed Ambulatory Care Extension, earmarked in the Five Year Facility Plan for FY 83.

MEDICAL ADMINISTRATION SERVICE

The Chief of MAS stated that overall staffing levels within his service are sufficient to meet the current work load.

The system wide problems associated with ward clerks are no better at VAMC Miami; turnover is too high and pay grades are too low. A tremendous amount of time is wasted training ward clerks, only to lose them within months because of the low pay grades. In the first place, the caliber of people that are attracted to this low paying job is somewhat questionable. The aforementioned problems can be related to file clerks as well.

The Chief stated that they are meeting or exceeding the standards for processing applications for Compensation and Pension Examinations.

The results of the latest Processing Time Study, involving 190 service-connected (SC) and 407 non-service-connected (NSC) veterans are as follows:

Regular Tour	SC	143.53 minutes	NSC	163.82 minutes
Irregular Tour	SC	97.49 minutes	NSC	104.90 minutes

The folloiwng figures designate the number of SC and NSC veterans in each bed category and the NHCU.

	SC	NSC
Medicine	62	142
Respiratory Care	3	7
Surgery	65	81
Psychiatry	59	67
NHCU	27	71
Drug/Alcohol Treatment Unit	5	16
Spinal Cord Injury Unit	3	15

Medical Service is responsible for 235 beds. This includes an 8 bed Medical Intensive Care Unit (MICU), a 5 bed Coronary Care Unit (CCU), a 16 bed Respiratory Care Unit, and a 10 bed Hemodialysis Unit. Plans and funding for renovating and consolidating the MICU and CCU have been approved for FY 82.

Staffing, according to the Chief, is adequate. A nationwide reduction in the number of resident positions will possibly reduce the number of residents in this service by 10 percent.

Nursing support was said to be minimal. Support from the Laboratory and Radiology needs to be improved. Additional space will be realized when the Research and Education Building is completed.

Surgical Service is currently finalizing their relocation and expansion project for the Surgical Intensive Care Unit (SICU). The present makeshift SICU is located on the 8th floor with 8 beds. The new SICU will move to the 3rd floor and maintain 10-12 beds.

With the exception of the possible reduction in funding for resident slots, the acting Chief was satisfied with the current staff complement. Of course, additional nurses are needed.

Previous dissatisfaction with open heart operations resulted in this facility discontinuing this type of surgery. (It was unofficially reported by two sources that a 20% mortality rate was realized). The present procedure is to contract this service from the University or, if medically possible, place the veteran on a waiting list for another VAMC. This procedure is dangerous because a 6-8 week unit is often required. When queried, the Chief of the Cardiovascular Laboratory stated that 6 veterans awaiting open heart surgery have had myocardial infarctions in the past four months. This facility is attempting to arrange an agreement with the University to once again allow VAMC Miami to perform open heart surgery. Professional sources indicated that the demand for this type of surgery is as high as 300 cases a year. Management indicated that the agreement is being finalized and surgery could begin within one month.

Psychiatry Service: The Chief of Psychiatry expressed his concern pertaining to the Alcohol and Drug Dependency Program (ADDP). The two major complaints of the Chief were the revolving hospitalization policy recently implemented (see ADDP) and the continued inability of this facility to provide proper detoxification in the ADDP. The Chief has requested that outpatients in the ADDP be exempt from the local policy. Management disapproved his request.

The Chief reported that staffing is reasonably adequate for the current work load. The majority of the Psychiatrists are board certified. Additional staff to

support outpatient activities are needed.

The mental hygiene clinic records 18-19,000 annual visits. This represents 2,130 service-connected, and 70 non-service-connected veterans.

A review of a list of staff to support this program appeared to be completely inadequate. A minimum of two additional social workers and two nurses are needed.

Ten thousand annual visits are recorded in the Day Treatment Center. Of the 120 veterans this represents only two are non-service-connected. The Chief expressed the need for a psychologist for this Center.

The lack of extended care psychiatric facilities in Medical District #12 is a problem shared by all the hospitals in this District. The Chief reported that transfers from one District to another is extremely difficult. Consequently, the Chief feels he is keeping patients unnecessarily long.

Alcohol and Drug Dependency Program (ADDP): As mentioned earlier, a recently implemented local policy is affecting the overall operation of this program to the point where VA Central Office intervention is essential.

The local policy was necessary to control the number of outpatient visits to VAMC Miami. However, an exception should be made with these patients because it is accepted knowledge (nationally) that these patients require a minimum of one year follow-up. The problems are numerous. A partial list is as follows:

1. Five of the 22 beds on this unit now are "reserved" for the overnight admissions.

COMMENT: In the first place, 22 beds are inadequate for this program, resulting in an ongoing waiting list. With these reserved beds, only 17 beds are available for inpatient treatment.

2. As of July, 1981,211 outpatients were being followed.

COMMENT: The ADDP staff related that 5 outpatients are admitted daily, Monday-Thursday, in order to stay ahead of the 90 day limitation. This disrupts and distracts inpatient activities. Additionally, it was reported that the patient comes in, receives an admission physical, has all his/her outpatient appointments cancelled, is admitted for one night, discharged the following day, and then is processed back into the outpatient activities. The unnecessary time and paperwork involved is astronomical.

3. Many patients refuse to be readmitted, thereby nullifying their right for continued follow-up care.

COMMENT: Even one night admissions (every 90 days) are scaring many veterans off for various reasons. The two most common reasons are family problems caused by readmission and jeopardizing the veterans work situation.

4. The one night admissions put a tremendous strain on the security atmosphere of this program.

COMMENT: With five daily admissions, the patients enrolled in this program have the opportunity for outside contacts like never before.

5. To a certain degree,new patients are refusing admission to the ADDP because of this policy of revolving hospitalization.

The need to provide detoxification within this program is another recognized shortcoming. Currently, veterans are detoxified on the Psychiatric or Medical wards. All staff members agree that this is undesirable. The need has been recognized for many years. Intoxicated veterans are occasionally referred to community resources or as one counselor related, "told to come back when they are sober."

The following is a list of the inpatient staff:

4	Registered Nurses
4	Nursing Assistants
3	Psychologists
2	Part-time Psychiatrists
2	Social Service Aides
1	Part-time Veterans Assistance Counselor

Antabuse is highly encouraged, but not mandatory, for first time admissions. If the veteran is readmitted, and it is medically feasible, then the use of Antabuse is required.

It was revealed that a 53% success rate is achieved for those veterans followed for two years.

The outpatient facility (located one mile away from the hospital) is where 60-65 patients receive their Methadone. Although an armed guard is present, the delivery of the drugs to this area is conducted by unarmed security personnel from the hospital.

This outpatient facility is in need of renovations. One counselor utilizes a closet/storage room for an office. One physician's office, where some patients receive examinations, is extremely small and does not have a sink. The back section is boarded off, and vacant. Minimal renovations would allow this section to be utilized, thereby creating the additional space required.

The 211 outpatients (129 alcohol-82 drug) are followed by the following staff that includes two non-drinking alcoholics.

3	Social Workers
1	Pharmacist
3	Clerks
2	Registered Nurses
1	Licensed Practical Nurse
1	Nursing Assistant
2	Part-time Psychiatrists
1	Part-time Evaluation Coordinator
1	Rehabilitation Technician

Spinal Cord Injury Unit is authorized 71 beds. It was reported that only 35 beds are operating because of the low census. The Chief reported that the average daily census has been 19 patients for some time now. Staffing was reported to be sufficient for 20 patients.

The present 12th floor location of this unit is undesirable. Space in the proposed Ambulatory Care Extension has been allocated for SCI. It was reported that

5,000 square feet of therapy space will be realized when and if this service relocates to the first floor in FY 84. Additionally, an apartment will hopefully be built into the new unit.

The need to establish a Hospital Based Home Care (HBHC) Program for SCI patients was expressed by the Chief. The HBHC program for the entire hospital currently attempts to follow SCI patients. The Chief, and other professionals within SCI Service, are not fully satisfied with this procedure. Conversely, the expense involved would be tremendous. The possibility of procuring a SCI physician to utilize the current HBHC staff may be a possible alternative.

With the assistance of Rehabilitation Medicine Service, SCI patients have a satellite group of therapists solely assigned to them. Occupational, recreational, physical, and corrective therapies are provided in addition to driver training.

Space, equipment, and record keeping were observed and disclosed as being insufficient.

Rehabilitation Medicine Service (RMS) maintains twenty beds. The Chief of RMS stated that this number was adequate. Staffing and space for the current work load were reported to be sufficient.

The Chief further stated that management has provided good support and the needs of this service are minimal.

This service provides vocational rehabilitation, physical, corrective, occupational, educational, and incentive therapies. It was reported that clinics are seldom closed because of leave requests.

NURSING HOME CARE UNIT

This unit, according to hospital sources, was never properly staffed or funded to allow 100% occupancy. Although 120 beds are available in this new, two story, solar equipped NHCU, only 90-100 beds are utilized. When the census is above 90, the staff is overworked to the point where patient care is affected.

Statistics requested from MAS indicated that there are 41 veterans on the NHCU waiting list. Some of these are occupying beds within the hospital. Additional staff must be allocated to allow utilization of all 120 beds. Discussions with management revealed that previous requests for 36.1 FTE have been fruitless. Ironically, plans for 2 additional stories (120 additional beds) are approved for FY 83. Although the need has been justified, VACO should ensure that these 120 beds are adequately staffed and fully utilized before compounding the problem.

The kitchen area and serving line built with this NHCU have never been utilized. Discussions with Dietetics personnel and NHCU staff indicate the problem is twofold. First, Dietetics Service feels utilization would be an unnecessary drain on labor and with OMB Circular A-76 hanging over their heads, this is one way to contain costs. The second problem is the additional staff that would be necessary to assist NHCU residents through the serving line. It was determined that 30 residents could ambulate through the line.

Problems pertaining to the lack of security within the NHCU were discussed. Some of the staff were concerned to the point of terminating their employment, or requesting assignments in the hospital. During the summation conference management acknowledged the problem and stated that they were in the process of addressing this

issue. The possibility of assigning a police officer to this unit was being deliberated.

There were 12 Category I; 31 Category II; 48 Category III; and 8 Category IV residents on the unit during the time of the survey. It was reported that VACO has approved a 50% Category I and II/50% Category III and IV split because of the lack of staff. The normal category division is 70% Categories I and II and 30% Categories III and IV.

The oldest resident is 101 years old and the youngest is 39 years old. Those residents interviewed were in high spirits and had very few complaints about the care they are receiving. The staff, on the other hand, is demoralized and concerned about the level of care they can provide.

MEDICAL SUPPORTIVE SERVICES

Audiology and Speech Pathology Service: The Chief of this service reported that staffing, equipment, and space are insufficient. The current work load justifies an additional audiologist and one more speech pathologist. No vacancies currently exists.

An ongoing contract, with Jackson Memorial, for Electronystagmography (ENG) testing is costing approximately $2,000.00 per year. Procurement of this equipment would not only be cost effective, but would be more convenient for patients and staff. Equipment costs were reported to be approximately 7,000 dollars. Management was made aware of this need during the summation conference.

Greater efficiency and more timely results would be realized with the purchase of additional equipment for performing Brainstem Auditory Evoked Response (BAER) testing. Currently, this service is sharing equipment with Neurology Service.

Three sound suites and one single booth were deemed adequate by the Chief. The need to update one of these suites was expressed and later discussed with management. This need will be investigated.

The present issue rate of 5-6 hundred hearing aids annually is constantly increasing. The Chief reported that he is in the process of applying for an increased stock of hearing aids. Occasionally, some veterans have to wait for aids. Although the number presently having to wait is minimal, without an increased stock, this problem could become serious. Prosthetics Service provides tremendous support.

Pharmacy Service is severely short of space. A tour of this service revealed that every conceivable flat surface is utilized for storage or work space. Personnel within this extremely congested service are demoralized. Accordion shelving is utilized but cannot even attempt to address the critical shortage of space. Discussions with management indicated that additional space will be allocated to Pharmacy Service. This space will become available when offices within the Medical Center move to the Research and Education Building in June 1982.

Forty-three percent of the 570,000 prescriptions processed at VAMC Miami during FY 80 were mailouts. Riviera Beach OPC processed 140,000 prescriptions during the same time period. Mailout prescriptions are processed within 24 hours by virtue of overtime. Prescriptions filled at the window were reported to involve 50 minutes turn around time. Service-connected veterans receive priority.

The Unit Dose Distribution System is needed at this facility. The only aspect of this system currently being performed is unit dose packaging. A recent request for 3 FTE to implement a pilot program on the NHCU has not been honored.

Nursing Service had 52 vacancies at the time of the survey. Thirty of these vacancies were for Registered Nurses.

A recently approved Special Salary Rate Increase has helped recruitment to a degree. The need to increase differential pay for evening and night shifts is widely recognized. Because of the increase in crime in the Miami area, nursing personnel do not want to work nights. Currently, the differential pay is 10% for the VA, and 20%+ for community hospitals. If VACO were to honor this request, it is the belief of the Chief that permanent evening and night shifts could be established.

A good recruitment source in the past has been other VA medical centers. Now, however, with the high crime rate in the Miami area, the reverse is true. Many nurses are leaving VAMC Miami for other VA assignments. Last year, the turnover rates were as follows: RN's=30%, LPN's=35%, NA's=25%. Morale was reported to be stable, but on the decline.

The Chief of Nursing related that she has made a request to management to use the incentive award program as a recruitment tool. If an employee refers a nurse to this facility, and the nurse stays at least 6 months, that employee will receive 100 dollars. (Local hospitals offer up to 1,000 dollars). Discussions with management at the conclusion of the survey revealed this method will be honored.

Despite the above listed vacancies, the Chief of Nursing stated that ample RN coverage is provided in special wards and on night and evening tours of duty.

Social Work Service: The Chief of Social Work stated that staffing was adequate for this facility, but will be inadequate for the Broward County Clinic. One additional social worker will be needed.

It was reported that four social workers are assigned to the outpatient area for the purpose of assisting veterans in locating alternative health care resources in the community. Although this was deemed adequate, the previously mentioned local policy of limiting outpatient care to 90 days will have a tremendous impact on the current work load.

There are presently 36 contract nursing homes utilized by this facility. One hundred veterans are placed in these homes with an average cost per patient day of $41.45. In addition, there are eight Residential Care Homes used with 18 veterans placed and supervised in these homes. Expansion of this program is obviously needed, but impossible with the current staffing level.

ANCILLARY SERVICES

Dietetics Service needs additional staff in the outpatient area. The present situation of having only one Dietitian for almost 300,000 outpatient visits is unacceptable. A minimum of two additional Dietitians should be added to support this area.

Approximately 610 people receive three meals daily at a raw ration cost of $3.96 for July 1981. Forty-four percent of these meals are modified diets. The possibility of supplying four daily meals to the NHCU is being investigated. By the time this report is published, selective menus will be discontinued. The sole

reason for this was reported to be OMB Circular A-76. This will help cut the costs and improve the bidding level. Also, in preparation for this circular, a reduction in force of 7 employees is expected. Consequently, because of the curtailment of selective menus, the patients are upset. Additionally, because of the reduction in force, employees are upset and appeared to have a vindictive attitude. Local contractors have already visited this facility several times.

Problems with a recently installed dishwasher have been bou. costly and inconvenient. The conveyor belts of the two traylines utilized are in need of replacement. Some tray carts should also be replaced. A project to improve and increase the cart lift shafts has been submitted locally. Currently, these lifts can transport 14 trays from the second floor to all patient areas up to the twelfth floor. The goal of 30 trays would be more cost effective and improve temperature retention.

Patient surveys reviewed, and interviews with patients, indicate that very few complaints pertaining to the food are realized. The patient meal consumed on one of the wards was hot.

Veterans Administration Voluntary Service (VAVS): The 207 regularly scheduled volunteers for The American Legion contributed 5,189 hours from October, 1980 to July 1981. For the same time period, 267 regularly scheduled American Legion Auxiliary volunteers donated 6,487 hours. The 45 volunteer groups amassed 150,000 hours from 770 volunteers, for calendar year 1980.

The American Legion VAVS Representative is David Pechenick. His deputies are Jack Lydick and William Womack. The American Legion Auxiliary Representative is Helen Pellack and her deputies are Dorothy Walters and Barbara Kepler.

It was reported that the expense and the lack of space for the Christmas Gift Shop have caused this program to be discontinued. The Chief reported that this unfortunate because the program was well received.

Recreation Service concentrates on therapeutic and not diversional health care. It is a separate service under the supervision of the Chief of Staff.

The Chief expressed the need for two additional therapists. One of these would be utilized to increase the therapy currently being provided on the Psychiatry units. The need is there.

When the one vacancy that presently exists is filled, five therapists will be available. The Chief reported that one therapist is assigned to the following areas: Spinal Cord Injury, General Psychiatry, Nursing Home Care Unit, and General Medical and Surgical. Weekend coverage was reported to be performed with Recreation Therapy Aides.

The Chief is new to this facility and stated that he plans to implement a complete reorganization process. Control of the buses and auditorium was reported to be a grey area. The Chief feels he will be able to eliminate any concerns in this area through discussions with management. The need for office space for this service was evident.

III. CONCLUSIONS

This highly complex and extremely active Medical Center needs additional staffing and funding to meet the increasing demands of the veterans. Statistics indicate that approximately 6,000 veterans are moving to Florida every month. The

ever increasing work load of VAMC Miami seems to support this figure.

For several years, VAMC Miami has exceeded their funded outpatient work load by over 30,000 visits. In an attempt to contain these visits, management recently implemented a local policy. This policy limits NSC veterans to 90 days follow-up care. Management reported that positive results have already been noted. The major problem associated with this policy pertains to alcohol and drug patients, who are mostly NSC veterans. Follow-up care for this type of patient is mandatory for at least one year. Consequently, after 90 days, these patients have to unnecessarily be readmitted to obtain an additional 90 day follow-up. As mentioned earlier, the problems this is causing are numerous. Discussions with the Director indicated that an exception could be made for these patients. However, follow-up telephone conversations with ADDP staff members revealed that, to date, no exception has been made.

Additional staff for the 120 bed NHCU must be authorized. The current staff complement dictates that a daily census of less than 100 be maintained. It was reported that a substantial waiting list is ongoing. Some veterans currently occupying hospital beds should be in this NHCU.

The proposed extension project for Ambulatory Care is essential to the overall operation of this facility. Many services, currently critically short of adequate space, will benefit from this project. Pharmacy Service should receive priority when/if this project is completed. The current plan is to start construction in FY 83.

Discussions with the Director pertaining to the last two JCAH surveys were generated. It was reported that the problems causing the one year accreditation received by Psychiatry for the previous two surveys have been corrected. The Director does not anticipate any problems with the JCAH survey scheduled for the end of this year. Some hospital personnel disagree.

A three story Research and Education building, with expansion capabilities, is currently under construction. Completion of this building is scheduled for June 1982.

Something must be done to address the parking problems currently being encountered. The possibility of leasing space nearby is being considered by VACO and management. Ideally, a parking structure should be constructed.

Because of the inadequacies previously mentioned with Security Service,(i.e. recruitment and retention problems, insufficient staff) the need for a closed circuit television system is great at VAMC Miami. Because this facility is located within a high crime area, increased surveillance is mandatory. Reports of "drifters" sleeping in unoccupied areas were received.

The problems associated with OMB Circular A-76 are already starting to affect patient care. The loss of job security, selective menus, and overall dedication are just a few of these problems. Although selective menus seem trivial to we that are healthy, a long term patient (i.e. SCI patient) views this as a Godsend. Those employees who were once dedicated and concerned about the veterans' welfare are fast becoming aware of the turmoil that surrounds the possible implementation of this circular. The strong possibility of a reduction in force appears to have even shattered the morale of those employees who will not be affected. Most of those employees interviewed had the same outlook: "It is only a matter of time before we are all unemployed".

The need to establish long term Psychiatric beds in Florida is a highly recognized problem. Reports received indicate that VAMC Gainesville is scheduled to implement 210 long term beds in the distant future. Any way that VACO can expedite this project would be extremely beneficial to the million and one half veterans in Florida.

The fact that VAMC Miami is providing good quality care even with inadequate staffing and funding, should not preclude VACO from providing additional resources. With increased funding and staffing, this facility could provide the level of care to the veterans that they deserve.

IV. RECOMMENDATIONS

1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize additional funding and personnel for the underutilized Nursing Home Care Unit.

2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to monitor the urgently needed proposed Ambulatory Care Extension project to ensure that this project is fully funded and constructed as scheduled for FY 83.

3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director confirm the problems outlined in this report pertaining to the Alcohol and Drug Dependency Program and take corrective actions.

4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director provide funding and staffing for the proposed 120 additional Nursing Home Care beds.

5. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize a system wide step increase in the entrance level of Security personnel.

6. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that authorization and funding be provided for the procurement of a closed circuit television system.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION Miami DATE OF INFORMATION August 1981

MEDICAL CENTER DIRECTOR T.C. Doherty

ASSISTANT MEDICAL CENTER DIRECTOR J.O. Linden

CHIEF OF STAFF Dr. C.A. Rosenberg

MEDICAL SCHOOL AFFILIATION University of Miami

	CURRENT FY 1981	LAST FY 1980
BED CAPACITY	841	805
OPERATING BEDS	748	713
AVERAGE DAILY INPATIENT CENSUS	571	572
OUTPATIENT VISIT (ACCUM.)	239,642*	293,133

*As of July 31, 1981

WAITING LIST Total 82 -(*) 78 Surgical (**) 3 Psychiatry (*) 1 Plastic Surgery

SERVICE-CONNECTED		None	
NONSERVICE-CONNECTED	Total	82	

EXPLAIN THE REASON FOR THE WAITING LIST:

(*) Unavailability of operating room time for elective surgery

(**) Drug Dependency Unit-Unavailability of beds-Present 22 authorized beds occupied

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 37,411

NUMBER OF APPLICATIONS ACCEPTED 23,285

NUMBER OF APPLICATIONS REJECTED 13,223

APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR 32,837*

NUMBER OF APPLICATIONS ACCEPTED 23,661*

NUMBER OF APPLICATIONS REJECTED 8,496*

*Through July, 1981

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1,892.7

CORE RATIO 1.7

STAFF PHYSICIANS (FTE) 126.0

CONSULTANTS ON THE ROLLS 221

ATTENDINGS ON THE ROLLS 162

RESIDENTS 162

MEDICAL STUDENTS 635 Rotating

PHYSICIAN EXTENDERS 1 PA, 6 Nurse Practioners

MAJOR PERSONNEL SHORTAGES *SEE ATTACHED LIST

PHYSICIANS (FT BY SPECIALTY) *

REGISTERED NURSES *

LICENSED PRACTICAL NURSES *

NURSING ASSISTANTS *

OTHERS *

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 34

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 38

SUMMARIES PENDING 25

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE Please see attached

OPERATING BEDS IN NURSING HOME CARE UNITS 120

FUNDS

AVERAGE COST PER PATIENT DAY $189.73

AVERAGE COST PER OUTPATIENT VISIT $67.36

AVERAGE COST PER NHCU DAY $101.10

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES $41.45

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) Thru June 30, 1981 (001 Medical Care Only) $69,137,319

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) FY 80 -$62,504,543 (001 Medical Care Only)

(Revised July 1, 1981)

MONTHLY 2507S

Month July 1981 VAMC-Miami, FL

1.	2507's Pending end of Last Month		345				
2.	2507's Received During Month		326				
3.	Total Workload		671				
4.	2507's Returned to St. Pete						
	A. By Examination		260				
	B. Failed to Report		42				
	C. By Other Methods		42				
	Total Returned		344				
5.	Pending Return to St. Pete						
	A. One Month or Less		259	79%	65		
	B. Two Months or Less		65	94%	90		
	C. More than 2 Months		3	100%	-		
	TOTAL PENDING RETURN		327				
6.	Request Days		28				
7.	Average Days		9366				
8.	Miscellaneous Exams						
	FBI		11				
	TDRL		4				
	PF		5				

7051b DATA SHEET

VETERANS ADMINISTRATION MEDICAL CENTER
MIAMI, FLORIDA

ADDITIONAL PERSONNEL REQUIREMENTS

Priority	Position
1-30	Registered Nurses
31-32	Registered Pharmacists
33	General Medical Technologist
34	Diagnostic Radiologic Technologist
35	Histopathology Technologist
36-37	Medical Equipment Repairer
38-39	Police Officers
40	Record Review Clerk
41-43	Eligibility Clerk, RBOC & Hosp.
44-46	Prosthetics Clerk, RBOC & Hosp.
47	Medical Aid/Sterile Supplies
48	Counseling Psychologist
49	Non-Invasive Cardiology Technician
50	Social Workers (Oakland Park Clinic)
51	Nurse Anesthetist
52	Dental Assistant
53	Secretary, Surgical Service
54	Personnel Management Specialist
55	Medical Photographer
56	Warehouseman

MEDICAL CENTER	AUTHORIZED VACANCIES
Dietitian	2
Cook	1
Food Service Worker-Part Time	4
Food Service Worker-Full time	1
Secretary	12
EKG Technician	1
Clerk Typist	8
Inhalation Therapy Technician	4
Police Officer	1
Data Transcriber	1
Pharmacist	3
Pharmacy Technician	1
Computer Aid (Laboratory)	2
Histopathology Technician	1
Medical Technologist	6
Medical Clerk	2
Warehouseman	2
Social Worker	2
Psychologist	1
Dental Laboratory Technician	1
Dental Hygienist	1
Dental Assistant	1
Registered Nurse	30
Licensed Practical Nurse & Nursing Asst.	22
Personnel Management Specialist	1
Assistant Chief, Voluntary Service	1
Podiatrist	1
Medical Equipment Repairer	1

AUTHORIZED VACANCIES (CONT.)

Audiologist	1
Voluntary Service Specialist	1
EEG Technician	1
Medical Records Librarian	1
Chaplain	1
Radiology Technician	3
Plumber	1
Carpenter	1
Maintenance Repair Technician	1

OAKLAND PARK OUTPATIENT CLINIC

Medical Technologist	3
Dental Hygienist	1
Dental Assistant	2
Pharmacist	2
Pharmacy Technician	4

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
VETERANS ADMINISTRATION MEDICAL CENTER
GAINESVILLE, FLORIDA

I. INTRODUCTION

During the week of January 25, 1982, a regularly scheduled visit was conducted to the Veterans Administration Medical Center in Gainesville, Florida. The purpose of this visit was to assess the quality, quantity, and timeliness of health care being provided to veteran patients.

Coordination: Notifications of the planned visit were forwarded to Mr. Malcom Randall, Director; Mr. Dyke E. Shannon, Department Adjutant; Mr. Robert R. Erskine, Department Service Officer; and Mr. James R. Drew, Hospital VAVS Representative, The American Legion, Department of Florida.

Statistical Information pertaining to personnel on duty, personnel shortages, patients on the rolls, and operating beds is attached.

Professional Affiliation: The affiliation with the University of Florida College of Medicine was reported to be excellent by all those interviewed. The theme of mutual dependence was mentioned on several occasions.

Hospital Accreditation: The results of the November, 1981, survey by the Joint Commission on Accreditation of Hospitals, have not yet been received. Medical Center management do not anticipate any problems.

MISSION OF MEDICAL CENTER

This VAMC was built in 1967 and is located in a university city of approximately 150,000 people. The city is located centrally in rural north central Florida and has four hospitals serving several counties in the region. Most of the patients live in the community and surrounding rural area within a 100 mile radius. In addition, many patients are referred from a much larger area in some specialties. The District provides a full array of services with the exception of chronic psychiatric care.

This 480-bed Medical Center provides primary, secondary, and tertiary acute care to medical, surgical, and psychiatric patients. A broad range of primary and specialized outpatient care, including mental hygiene clinic and alcohol dependency treatment, are provided at Gainesville. Primary and specialized outpatient care, including mental hygiene and day treatment, are provided at the Jacksonville Satellite Clinic. A Vet Center is also operational in Jacksonville.

A new 120 bed Nursing Home Care Unit was opened in January, 1982. Providing nursing shortages do not interfere, 100% occupancy is expected by the end of April, 1982.

The 440 operating beds are designated as follows:

Psychiatry	60
ADTP	30
Medicine	134
Neurology	30
Surgery	186

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: According to the Director, both staffing and funding are marginal. Major personnel shortages have been identified and submitted to VA Central Office.

Serious shortages within the Nursing Service have caused the closure of 40 surgical beds. (Last summer, 70 beds were closed.) Only 21 RN positions are vacant according to the ceiling, but the need for an additional 40 positions beyond the ceiling has been identified. Although this facility has experienced retention problems in the past, recruitment difficulties are relatively new for this hospital.

A new 120 bed NHCU was recently activated. It was predicted that all the beds would be occupied by the end of April, 1982. Again, however, the problems of obtaining enough nurses may delay 100% occupancy. The number of NHCU nurses needed are in addition to the aforementioned shortages. Further discussions on the inability to activate all 120 beds will follow under Nursing Service.

It appears that the urgent need for long-term psychiatric beds in Medical District #12 may be addressed in the near future. It was reported that a project is currently in the planning stages to construct a 290 bed building at the Gainesville VAMC for chronic long-term psychiatric patients. The need has been long identified and supported by everyone involved. The University has committed itself to providing support for this project. To date, however, no VA construction money has been appropriated.

Further discussions on the urgent need for this project will follow under Psychiatry Service.

Professional Services: The Chief of Staff (COS) reported several vacancies (list attached). The current staff was reported to be highly qualified. The majority of the physicians are board certified.

The COS stated that support from the University has been a tremendous asset to this facility. During the loss of a specialist, the University provides the VAMC with coverage until the vacancy is filled.

The COS further emphasized the need for long-term psychiatric beds for Florida veterans. Tentative plans are for a 290 bed service. This would provide 200 additional beds and include the 90 bed unit currently in existence at this facility. It is unknown if this proposed building will be physically attached to the Medical Center.

Assistant Director: The Assistant Director stated that there were no key vacancies in those services under his supervision.

The Assistant Director related that the problems associated with recruiting nurses is a major concern. One neighboring hospital has increased nursing salaries over 75% in the last two years. In an effort to improve recruitment, this facility has recently submitted a request for special minimum salary rates for registered nurses.

Security Service: The need for two additional officers has been justified and submitted to VA Central Office. Currently, the Chief feels that his staff complement of 10 officers is not sufficient. Officers are only allowed to utilize their leave when they are assigned to the day shift, which is causing morale problems. It was reported that the hospital is not sufficiently patrolled at night.

Incidents were reported to be numerous. A partial list includes assaults on the officers, sexual assaults, bomb threats, and firearm confiscation. Retention was reported to be a minor problem but recruitment is extremely difficult. Officers start at the GS-5 level at this facility. Security personnel expressed concern about not receiving additional positions when the new 120 bed NHCU was opened.

REGIONALIZATION

Management reported that the initial submission of Medical District Initiated Program Planning (MEDIPP) appears to be a step in the right direction. Needs are being identified at this time. The possibility of existing services within Medical District #12 that are duplicated is also being investigated.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

New employees receive a comprehensive orientation and training program which begins on their first day of employment. Various aspects of their jobs are discussed, including hospital policies, fringe benefits, and salary information.

Films, lectures, and a question and answer period precede a tour of the hospital. Employees are then introduced to their supervisors and inservice training sessions are conducted.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE

The acting Associate Chief of Staff for Ambulatory Care expressed the need for one additional physician. During the Summation Conference, the Chief of Staff revealed that a physician will be recruited after the new Chief for this service has been selected.

Space is the major shortcoming associated with this service which has outgrown itself in the last two years. Possible solutions are being evaluated, but are limited. If the psychiatric building is constructed, the domino effect will provide additional space in this area.

MEDICAL ADMINISTRATION SERVICE

Discussions, pertaining to the 123 service-connected and 215 non-service-connected veterans scheduled for admission, were generated with the Chief of MAS and management. It was reported that the greater majority of these scheduled admissions were for elective surgery. Because of the nursing shortage, Surgical Service is experiencing a backlog.

The following figures represent the entire Medical Center, Fiscal Year to date:

Average Daily Census	344
Turnover Rate	264.1%
Occupancy Rate	83.0%
Average Length of Stay	11 days

Discussions with the Chief, and a review of the records, indicate the applications for Compensation and Pension Examinations (2507's) are completed well within the time limits established by VACO. The majority are completed within 30 days.

The following list designates the number of service-connected (SC) and nonservice-connected (NSC) patients in each bed category.

Service	SC	NSC
Medicine	42	52
Surgery	57	83
Psychiatry	44	9
Alcohol Treatment Unit	8	14
Neurology	6	11

Five additional FTEE have been recently awarded to provide 10 part-time ward clerk positions. The Chief related that this will eliminate his prior concern pertaining to insufficient P.M. ward clerk coverage.

BED SERVICES

Medical Services has 134 operating beds at its disposal which includes a 6 bed Medical Intensive Care Unit and a 4 bed Coronary Care Unit.

With the exception of adequate nursing support, the Chief of Medicine stated that he is satisfied with the current staff complement. Special nursing needs include Intensive Care Nurses. On occasion, according to the Chief, contracts have to be established for intensive care beds in the community. Additionally, the Chief reported that some patients are moved out of the intensive care units prematurely. Telementry monitoring equipment on the wards is utilized in these cases. No incidents were reported concerning these premature moves.

Surgical Service: As previously mentioned, 40 surgery beds are closed due to nursing shortages. The remaining 186 operating beds includes a 9 bed Surgical Intensive Care Unit (SICU). The justified need to expand the SICU to 15 beds is currently being evaluated.

Eight operating rooms are available. During a recent construction project, four rooms were closed. As of late, two were closed due to nursing shortages. At the Summation Conference, the COS reported that seven ORs are again being utilized. Last fiscal year, 4389 surgical procedures were performed.

Major personnel shortages within this service are listed on the attached sheet.

Psychiatry Service: In 1975, a VACO study identified the need for 374 additional psychiatric beds in Medical District #12 by 1985. Currently, this District does not have any long-term psychiatric care capabilities. The obvious need is increasing daily. A proposed project for a 290 bed Psychiatric Building at VAMC Gainesville will provide 200 additional beds and relocate the 60 psychiatry and 30 alcohol treatment beds currently in the hospital.

It is suspected that the MEDIPP process will stall this project because of the requirement to once again, identify the need. It was reported that this project was in VA's top ten, indicating the necessity to provide long-term psychiatric beds to Medical District #12. It is certain that any further reviews will only show the need has increased. From both the monetary aspect and the welfare of Florida veterans, further postponements of this project will be costly.

Records reviewed revealed that 63% of the Gainesville psychiatry discharges are service-connected veterans, 42.7% of which are SC for psychiatric conditions. Acquiring long-term beds from other VAMCs and contract hospitalization is extremely difficult. The acting Chief of Psychiatry expressed two areas of concern related to this. First, if this VAMC is unable to refer long-term patients to other facilities, eventually all 60 beds will be occupied with chronic patients. A recent survey identified that there are approximately 10 chronic care patients in this service at all times. Secondly, chronic care patients receive proper care in a chronic hospital.

Vacancies for 2.5 Attending Physicians for the inpatient unit were identified. Additionally, the acting Chief said one additional psychiatrist is needed.

Fiscal Year 1981 inpatient statistics revealed there were 1134 admissions, the majority of which were SC veterans. The average length of stay was 28 days. During FY 81, the Mental Hygiene Clinic recorded 16,050 individual visits and 1423 group visits. Staffing for the MHC was reported to be insufficient.

A good array of treatment modalities include Behavior Modification Programs, Biofeedback, Relaxation Therapy, Assertiveness Training, Psychopharmacology, and Electroconvulsive Therapy on occasion.

Alcohol Dependence Treatment Program (ADTP): According to the Chief of this 30 bed, 30 day inpatient program, the need for two additional alcohol counselors has been identified. Until these counselors are available, adequate follow-up procedures cannot be accomplished. Current staff consists of 1 Director, 1 Staff Psychologist, 1 Clinical Psychologist, 2 Vocational Counselors, 1 Social Worker, 7 RNs, 4 LPNs, 1 Nursing

Assistant, 1 Dietitian, and one Secretary.

The average age of veterans enrolled in this program was reported to be 49 years old. Five percent of the clients never finish the program. The Chief related that 33% of the graduates stayed abstinent for one year.

Although not required, it was stated that 15-20% of the veterans volunteer to take Antabuse. After two weeks into the program, patients are allowed weekend passes. Upon their return, a breathalyzer test is required. If the outcome of this test proves the veteran has been drinking, immediate dismissal is the result. Those veterans who leave the program, even against medical advice, are allowed readmission according to availability.

Approximately 250 active outpatients attend weekly meetings during the first 6 months. After this time, monthly meetings are conducted for as long as the veteran feels is necessary. Usually, 100 veterans are present at these monthly meetings.

The usual waiting time from screening to admission is 7-10 days. The longest time was reported to be 2 weeks. Ten percent of the clients are legal referrals. Some are given the option of this program or jail. Success with this type of referral was reported to be good.

Alcothon House, Inc. (Halfway House): Six veterans are currently residing here at a per diem rate of $17. A two month contract is established with the possibility of an additional 30 days if necessary. The average length of stay for veterans was reported to be 90 days.

The total bed capacity of 17 is divided between two dorms. Eight beds are in the front building, with nine in the back building. The VAMC inspection team has rightfully disallowed veterans to occupy beds in the back dorm. Fire & safety safeguards and the overall ambiance of this back area must be addressed before veterans are permitted to reside there.

According to the Supervisor, actual costs per day equate to $30 per resident. Therefore, it was predicted that after July 1982, this house will not take any more veterans if the per diem rate of $30 is not granted. This is the only halfway house available to VAMC Gainesville. However, after touring the physical structure, it would be difficult to support a $30 per diem rate.

Residents are required to attend 3 Alcoholics Anonymous meetings per week. An 11:00 p.m. curfew is enforced. Residents must also be actively seeking employment.

NURSING HOME CARE UNIT

This new 3 story building presents a high level of ambiance. Both the exterior and the interior are extremely attractive. Bright roomy patios provide easy access to the outside for residents. Additionally, balconies are provided for the majority of the rooms. Most rooms are 2 bed rooms. There are 8 private rooms on each floor.

During the survey, 18 of the 120 beds were occupied. Assuming all the nursing positions can be filled, 100% occupancy will be completed by April, 1982. Most sources interviewed, however, do not think this date will be met because of the inability to recruit nurses.

Shortcomings associated with this new building appear to be minor on paper, but are already causing disruptions within the unit. The major problems are insufficient office space and a complete lack of storage space. Besides having no space to store the residents belongings, there is no area to store the tremendous amount of equipment that is needed to lift and move the residents. Because four elevator shafts were constructed, but only three elevators were installed, the empty shaft is being utilized for these purposes. Additionally, because there were no laundry rooms provided, the soiled utility rooms are being utilized for this purpose.

Rehabilitation Medicine Service: According to the Chief, who is half-time, staffing is adequate for the present work load. Physical, occupational, and recreational therapies are available.

Sufficient staff was awarded to support the new NHCU. The Chief reported that these personnel will devote the majority of their time to NHCU residents. The NHCU is well equipped with rehabilitation equipment. The physical therapy equipment in the hospital is reportedly scheduled for replacement.

A heated therapeutic swimming pool is available. However, because this pool is not enclosed, the Chief reported that it can be used only during the summer months. Discussions with management indicated that this need will be investigated, and if financially feasible, something will be done to allow full utilization of this valuable rehabilitation tool.

Both waiting space and office space are lacking throughout this service with no immediate relief in sight. The lack of an activities of daily living (ADL) area was discussed with the Chief. Although the Chief reported the need to be minimal, other RMS personnel related that such an area would be beneficial.

Audiology and Speech Pathology Service: The Chief expressed the immediate need for one additional audiologist and a full-time secretary.

During FY 81, 150 examinations for hearing aids were recorded and 74 hearing aids were issued. Most veterans must travel to VAMC Tampa to receive aids. Hearing aid evaluation requests are honored within one day for inpatients, and within 4 weeks for outpatients. Two double sound booths are available.

The Chief reported that equipment needs are minimal at this time. A request has recently been submitted for a $13,000 Audiometer. The Chief is confident that this request will be honored.

Pharmacy Service is currently scattered throughout the hospital. The ongoing renovation project will greatly improve the entire operation by consolidating this service and providing the necessary space.

Recruitment for two vacancies for Pharmacy technicians is ongoing. The Chief has justified the need for two additional pharmacists, one procurement technician, and one administrative assistant. These requests have been recently submitted to management.

This service has been converting to the Unit Dose Distribution System over the past four years. As a result, the number of employees has increased from sixteen to forty-four. If the aforementioned requests are honored, the Chief feels his staff will be adequate. Only then will time be available to review patient profiles, reduce waiting times, and eliminate the occasional "lick and stick" type of pharmacy practices that are results of insufficient staff.

Approximately 50% of the 240,000 prescriptions filled last year were mailouts. These are processed within two days according to the Chief. Prescriptions filled at the window required an average of 50 minutes processing time. Veterans interviewed were required to wait 50-60 minutes but were understanding. Upon completion of the renovations, processing times will undoubtedly be reduced.

Nursing Service is currently experiencing serious recruitment and retention problems. Just one year ago, this service maintained a stable workforce of nurses. As of late, however, community hospitals have substantially increased nursing salaries. This, coupled with their attractive benefits package is causing VA nurses to transfer, and new nurses to bypass the VA altogether.

As a consequence, this service is 21 RN positions below their ceiling. Beyond this, the need has been identified for an additional 40 RNs to provide adequate staff to activate the 40 beds currently closed. The turnover rate for RNs was reported to be over 40 percent.

This nurse shortage problem has been compounded with the opening of the NHCU. The Chief reported 17 RN and 10 LPN vacancies for the NHCU alone. These vacancies are not included in the aforementioned in-house vacancies. Serious doubts as to the ability of providing staff for 100% occupancy of the NHCU were generated by many professional sources.

In an effort to lessen the work load of the nursing staff, management has authorized additional FTEE for supportive personnel. Additional ward clerks (5 FTEE), building management personnel (4.5 FTEE), and escort people (2.0 FTEE) have been added.

Although many other remedies are being investigated, the major concern at this point is pay. For this reason, a recently submitted request for Special Salary Rate Increases must be honored and expedited by VACO.

Social Work Service is inadequately staffed. The Chief has requested two additional Social Workers on several occasions, to no avail. One of these workers would be utilized to provide the needed support to the Medical and Surgical Wards. Currently, one social worker is responsible for a minimum of 90 patients. The second social worker is needed to support the community care programs. The Chief reported further duties of this person would be to conduct the required inspections and to expand the Residential Home Care Program (RHCP). Management considers these

requests to be valid, but resources are not available at this time.

The RHCP involves 5 homes and less than 10 veterans. The need to expand this program was expressed by social work staff, but cannot be accomplished until additional support is received. Presently, 46 veterans are being followed in 30 community nursing care homes at an average daily cost of $43.75.

ANCILLARY SERVICES

Dietetic Service has always utilized the minimal food concept. Reportedly, it was the forerunner of the nine VAMCs currently under this concept. This total convenience food method was reported to be working well by the Chief. Before a requested entree is listed on the menu, a test panel has to award a passing score to said entree. Reportedly, patients are included on these panels. Patients interviewed, and the patient meal I consumed, attest to the tastiness and appearance of the meals. However, the nutritional value and savings of the prepackaged food is questionable. Ongoing cost studies must be closely scrutinized, to the point of conclusion, before more VAMC's implement this concept.

The Chief reported staffing to be inadequate by 1.5 Dietitians. These personnel would be utilized to provide support to the Alcohol Dependency Treatment Program, to maintain a full-time Nutritional Clinic, and to improve nutritional assessment documentation in the patients' records. Management is aware of this need.

Approximately 10,000 rations are served monthly at a raw ration cost of $4.02. Forty-five percent of these rations are modified diets. One small dining room is available for volunteers and outpatients. Psychiatry and ADTP patients eat on the wards in makeshift dining rooms. Food is shipped in bulk to the dining room in the NHCU. The remainder of the patients receive their meals at bedside. Their discussions indicate that the pellet system is effective in retaining the proper temperature of the foods. Very little waste was observed.

Veterans Administration Voluntary Service (VAVS): There are 24 organizations represented on the VAVS Advisory Committee. The American Legion Representative is Mr. James Drew. The Deputy Representative position is vacant. The American Legion Auxiliary Representative is Mrs. Ruth Goodermuth. Presently, there is not a Deputy Representative.

Approximately 454 regularly scheduled volunteers contributed 50,759 hours during FY 81. During the same period, 6 American Legion regularly scheduled volunteers donated 1375 hours, and 6 American Legion Auxiliary regularly scheduled volunteers amassed 1249 hours.

Plans are underway to implement various programs for the new NHCU. Youth volunteers are being recruited for this purpose. Last year, 41 high school students volunteered at this facility.

III. CONCLUSIONS

Although the cost associated with the proposed 290 bed Psychiatric Building is monumental, so is the need for long-term Psychiatric beds in

Medical District #12 which has a veteran population in excess of 1.3 million.

It was stressed that long-term psychiatric referrals to other VAMCs have not worked out well. Even with restrictive referrals, during FY 1980, Medical Districts 9 and 10 made 264 psychiatric discharges of patients residing in District 12. Seventy-six percent of these out-of-district discharges were from the North Florida area, where VAMC Gainesville is located.

A further review of documents revealed the following: "In FY 1981, there were 834 emergent Psychiatric VAB (VA Beneficiaries entitled to VA care) admissions to private facilities via contract hospitalization, due to unavailability of VA beds in M.D. 12. Three hundred and one (301) of the admissions to private facilities were veterans from the Gainesville/Lake City area. Less than half of these veterans were eventually transferred to a VA facility, indicating a shortage of acute care psychiatry beds..."

This facility has the full support of the Dean of the College of Medicine, and Chairman of the Department of Psychiatry, University of Florida, to work with the VA in staffing the chronic Psychiatric facility and to work to further develop innovative programs for this new facility.

Sources in VA Central Office readily quote figures when discussing the number of psychiatry beds in Medical District #12. However, long-term psychiatry beds are non-existent. Any further postponements or reassessments of this project will not be in the best interest of the veterans, not to mention the increasing costs.

Management at the local level is exploring every feasible avenue in an attempt to stabilize their workforce of nursing personnel. Assistance from VACO, in the form of honoring a recent request for increased salaries, is sorely needed. Over the last year, many career employees have left the VA to area hospitals. Although other incentives must be addressed, the minimum salary rate increase would place this VAMC in the competitive market. Until authorization to increase the salaries is received, career nurses will continue leaving the VA virtually everyday.

Currently, due to nursing shortages, 40 surgical beds are closed. Additionally, the threat of not being able to allow total occupancy of the NHCU is a strong possibility. It is understood that salary increases will not eliminate all the concerns, but will again allow this facility to compete with local facilities.

Through numerous observations and conversations with patients, visitors, volunteers, and management, it was learned that the mission of the Medical Center was being met. Furthermore, it was evident that timely and quality health care was being delivered.

IV. RECOMMENDATIONS

1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize funding and construction of the proposed 290-bed Psychiatric Building.

2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize the recently submitted request to increase minimum salary rates for Registered Nurses at VAMC Gainesville.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION Gainesville, Florida DATE OF INFORMATION January 15, 1982

MEDICAL CENTER DIRECTOR Malcom Randall

ASSISTANT MEDICAL CENTER DIRECTOR Alan G. Harper

CHIEF OF STAFF Richard M. Whittington, M.D.

MEDICAL SCHOOL AFFILIATION University of Florida College of Medicine

	CURRENT FY 1982 as of 1/1/82	LAST FY 1981	
BED CAPACITY	480	480	
OPERATING BEDS	440	421	
AVERAGE DAILY INPATIENT CENSUS	344	380	
OUTPATIENT VISIT (ACCUM.)	22,046	104,071	Gainesville
	9,832	43,648	Jacksonville
WAITING LIST:			
SERVICE-CONNECTED	0	0	
NONSERVICE-CONNECTED as of 1/1/82	274	152	

EXPLAIN THE REASON FOR THE WAITING LIST:

Two operating rooms closed; 40 beds closed; shortage of nursing personnel

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 20,918

NUMBER OF APPLICATIONS ACCEPTED 16,612

NUMBER OF APPLICATIONS REJECTED 4,306

APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR as of 4,972 as of 1/1/82

NUMBER OF APPLICATIONS ACCEPTED 3,630 as of 1/1/82

NUMBER OF APPLICATIONS REJECTED 1,342 as of 1/1/82

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1363.0

CORE RATIO 1.99

STAFF PHYSICIANS (FTE) 73.1 Authorized

CONSULTANTS ON THE ROLLS 113

ATTENDINGS ON THE ROLLS 11

RESIDENTS 94 Paid

MEDICAL STUDENTS 30 Daily Rotation

PHYSICIAN EXTENDERS 8 PAs and 4 Nurse Practitioners

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) 1 Int. (Jax) 2 Psychiatrists 1 Dermatolog
1 Gen. Surg. 1 Vascular 1 Thoracic
1 Gerontology
Continued on Attachment

REGISTERED NURSES 61

LICENSED PRACTICAL NURSES 12

NURSING ASSISTANTS 0

OTHERS Listed on Attachment 29

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 123

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 215

SUMMARIES PENDING 101 as of 12/29/81

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE 206

OPERATING BEDS IN NURSING HOME CARE UNITS 120

FUNDS

AVERAGE COST PER PATIENT DAY $ 227.02

AVERAGE COST PER OUTPATIENT VISIT 80.94

AVERAGE COST PER NHCU DAY -

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES 43.03

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) 46,765,832

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) 39,436,178

Total VAMC Budget Allocation Including Research - This Year 48,441,463
Last Year 40,950,246

(Revised July 1, 1981)

MAJOR PERSONNEL SHORTAGES

Physicians (FT by Specialty) Continued

1 Cardiologist
1 Gastroenterologist
1 Oncologist
1 Nephrologist
0.5 ENT
0.5 Urologist
0.5 Orthopedist
0.5 Ophthalmologist

Others

Anesthesiology	1	Anesthesiology Aid
Dietetics	1	Dietitian
Fiscal	1	Payroll Clerk
Laboratory	2	Laboratory Technicians
	1	Laboratory Clerk
Medical Administration	5	Ward Clerks
	3	Clinic Clerks
	3	File Clerks
	1	Telephone Operator
Personnel	1	Personnel Clerk
	1	Personnel Management Specialist
Pharmacy	1	Pharmacist
	2	Pharmacy Technicians
Psychology	1	Rehabilitation Specialist
Rehabilitation Medicine	1	Occupational Therapist
	1	Physical Therapist
Social Work	1	Social Worker
	1	Social Work Associate
JAX OPC	1	File Clerk

F A C T S H E E T

Gainesville V.A. Medical Center

MEDICAL CENTER

- Operating Beds - 462
- Occupancy Rate (percentage) - 82.3%
  (Indicates how quick the turnover)
- Turnover Rate (percentage) - 285.7% (approximately 3 persons per bed per month)
  (Indicates how active)
- Patients Treated (in-patient) - 13,393
- Out-Patient Staff Visits - 146,836

EMPLOYMENT AND FUNDING

- Employment - 1,265
- Funding - $46,214,859

* Figures based on Fiscal Year 1981

F A C T S H E E T

Tampa V.A. Medical Center

MEDICAL CENTER

- Operating Beds - 697
- Occupancy Rate (percentage) - 78.2%
  (Indicates how quick the turnover)
- Turnover Rate (percentage) - 320.9% (approximately 3¼ persons per bed per month)
  (Indicates how active)
- Patients treated (in-patient) - 21,509
- Out-Patient Staff Visits - 200,290

EMPLOYMENT AND FUNDING

- Employment - 1,790
- Funding - $61,331,683

* Figures based on Fiscal Year 1981

FACT SHEET

Bay Pines V.A. Medical Center

MEDICAL CENTER

- Operating Beds - 673
- Occupancy Rate (percentage) - 85%
  (Indicates how quick the turnover)
- Turnover Rate (percentage) - 131.5% (approximately 1 1/3 persons per bed per month)
  (Indicates how active)
- Patients Treated (in-patient) - 9,602
- Out-Patient Staff Visits - 176,598

NURSING HOME

- Operating Beds - 210
- Occupancy Rate - 78.1%
- Turnover Rate - 4.1 %
- Patients Treated - 300

DOMICILIARY

- Operating Beds - 200
- Occupancy Rate - 86.5%
- Turnover Rate - 10.8%
- Patients Treated - 340

EMPLOYMENT AND FUNDING

- Emplyment - 1,683
- Funding - $75,145,035

* Figures based on Fiscal Year 1981

FACT SHEET

Miami V.A. Medical Center

MEDICAL CENTER

* Figures based on Fiscal Year 1981

- Operating Beds - 743
- Occupancy Rate (percentage) - 75.5%
  (Indicates how quick the turnover)
- Turnover Rate (percentage) - 247.8% (approximately 2½ persons per bed per month)
  (Indicates how active)
- Patients treated(in-patient) - 17,246
- Out-Patient Staff Visits - 282,259

NURSING HOME

*Figures based on Fiscal Year 1981

- Operating Beds - 120
- Occupancy Rate - 80%
- Turnover Rate - 8.1%
- Patients treated - 191

EMPLOYMENT AND FUNDING

* Figures based on Fiscal Year 1981

- Employment - 1,900
- $71,624,443

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 15, 1982.

Chairman G. V. "SONNY" MONTGOMERY,
House Veterans Affairs Committee,
Cannon House Office Building.

DEAR MR. CHAIRMAN: As you are aware, I recently took a tour of the four largest VA hospitals in the State of Florida. The opportunity to observe the conditions of the hospitals first-hand was an enriching experience for which I am most appreciative.

During the three day tour I visited the Gainsville, Bay Pines, Tampa, and Miami facilities. At each location I was presented with the particular concerns of the Administrators, veterans and staffers. I would like to take this opportunity to share with you the concerns and interests with which I became familiar.

Several major concerns are shared among the facilities. Firstly, long-term psychiatric facilities, each director pointed out that Florida has no facility for treating long-term psychiatric patients. As it is handled now a Florida veteran who needs this long-term care cannot be treated in Florida and must be sent to another state. It is often difficult to do this since most other states do not have the available bed space.

Additional funding for outpatient treatment in Florida is a very major concern. With the tremendous increase in veteran population in Florida, and the shortage of funds for Florida VA outpatient clinics, many veterans with non-service-connected disabilities are going untreated.

Three of the four centers discussed a need for inhouse radiation therapy. Bay Pines, Tampa, and Gainsville each mentioned that radiation therapy is contracted out and it was mentioned that it could be done more cost effectively if the VA facilities could provide this treatment.

Each facility expressed a need for computers. At the present, none of the before mentioned VA facilities have any form of computers.

An overall increase in funds for outpatient care is greatly needed due primarily to the increase in the veteran population. Much of the criticism of the Florida facilities comes from veterans who since moving to Florida, from another state, have been denied medical treatment.

In summary, my findings from the tour are the need for long-term psychiatric facilities, increased funding for outpatient treatment, the addition of inhouse radiation therapy, and computers, along with an overall increase in funding for outpatient care. Now that the problems are clearly defined, I look forward to working with you in finding the solutions.

Again, thank you for your assistance in helping me make my tour a successful one.

Warm regards.

Sincerely yours,

DANIEL A. MICA,
Member of Congress.

PREPARED STATEMENT OF HON. BILL MCCOLLUM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr Chairman, since being elected to serve as the Representative of Florida's Fifth Congressional District I have continually stood up for the right of veterans to receive quality health care. Veterans have earned this right through the sacifices they have made in defense of this country and in defense of the values and principles upon which this nation was founded

Because of my concern in these matters, I am here today, along with other members of the Florida delegation, to tell you that the quality health care which veterans so rightly deserve, is being threatened in Florida. To put it simply, Florida has a problem of numbers—a great increase in the number of veterans choosing to permanently reside in the state. According to the Veterans Administration, there are now nearly 1.4 million veterans living in the state of Florida, representing 15 percent of Florida's population and nearly 5 percent of the total veteran population in the country. The number of veterans living in the state can be expected to increase further and veterans health care can be expected to continue to decline unless appropriate veteran facilities are provided for.

Because demand for veterans health care facilities in Florida is significantly outstripping availability, many problems are becoming apparent. Transportation to and

from VA hospitals has become a serious difficulty for many veterans who are finding that VA facilities are not located within a reasonable distance from their residence, even in areas where they live within a fifty mile radius of a VA hospital because growth and congestion have outpaced transportation capacities with no relief in sight. VA hospitals are becoming overcrowded and unless a veteran has a service-connected disability it is extremely difficult for many veterans to be admitted. Veterans who would normally receive immediate care in other states face admission delays and the great demand on each relatively resource-limited facility will certainly not result in any improvement in the care delivered to the patients. Furthermore, outpatient facilities which could alleviate many of the problems simply aren't existent or easily accessible in many areas.

I urge the Subcommittee to ensure that Florida is allocated the resources necessary to provide for its growing veteran population.

PREPARED STATEMENT OF HON. EARL HUTTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, I appreciate your allowing me to share with the committee the major concerns expressed by veterans in my district of Florida.

There are an estimated 97,000 veterans in the northwest Florida area. This represents almost one out of every five citizens in my district. Coupled with this large veteran population, is an estimated 30,000 active duty military personnel. From these numbers alone, its easy to recognize the value quality VA medical facilities carry in my area of Florida.

Veteran constituents in northwest Florida express much the same concerns as most veterans throughout the State of Florida; despondency over the lack of sufficient medical supplies in VA and military hospitals, frustration over the great distance required to travel in order to receive quality medical attention and disillusionment over cost containment programs by both military and VA facilities which seem to "contain costs" by directly impacting on veteran services. I again reiterate these legitimate concerns.

The greatest need of our verteran population continues to be quality medical care. This is a debt we must not lose sight of. Due to their unselfish dedication and service in answer to our country's call to arms, these Americans must be assured that we stand resolved to maintain and improve present VA hospitals and clinics. This resolve must be clearly expressed to our active duty military personnel and future recruits as well. Preserving our Nations VA medical services is of utmost importance, if we are to retain and recruit quality military personnel. I don't think this point can be emphasized enough. The promises we make and keep will directly effect the type of soldier we recruit and retain in the future.

Let me take this opportunity to express my appreciation to the committee for your support of the new VA clinic to be constructed in the Pensacola area, with activation set for 1984. I would like to especially thank my colleague Don Fuqua for his leadership and perseverance in making sure this much needed clinic be placed in northwest Florida. With an estimated 52,000 veterans in Escambia and Santa Rosa Counties alone, the VA determination to locate the clinic in Pensacola assures that most area veterans will be well served. I commend the committee and my colleague Don Fuqua for the diligence and farsightedness in supporting the Pensacola area VA outpatient clinic.

PREPARED STATEMENT OF HON. BILL CHAPPELL, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

At the outset, I would like to compliment the subcommittee for holding hearings to deal with the availability of adequate health care facilities in Florida. Such an effort can only lead to positive and beneficial action by the Congress.

As the members of the subcommittee are well aware, the rapid growth of the veteran population in Florida is well documented. In 1978, Florida's veteran population was 1.279 million—the largest of any State in the Southeastern region. This figure has been increasing since that time at a rate of approximately 6,000 new veterans per month. Of additional significance in the case of Florida is the fact that its population of older veterans (World War I and World War II) constitutes more than one-half of all its veterans, a significantly higher proportion than that of any of the other States in the region.

These facts combine to make Florida an area of critical concern to both the subcommittee and the Congress. Indeed, the Senate Appropriations Committee directed

the Veterans' Administration in its 1982 HUD-independent agencies report to undertake an in-depth study at the medical district level of Florida's anticipated requirements for VA health facilities to meet that demand.

Mr. Chairman, I have no access to a crystal ball but I can assure you that the need is great and the facilities are not presently available.

It was with this concern in mind that I have introduced, in the past three Congresses, a bill to provide for a Veterans Administration hospital in the Halifax area of Volusia County, Florida. In the 97th Congress this initiative is contained in H.R. 797, which is presently pending before the Veterans Affairs committee.

While population and estimated use rates clearly warrant the establishment of a hospital, budgetary restraint has required us all to lower our sights a little. Accordingly, for the past several years, I have been working to have an outpatient clinic established in the Daytona Beach area of Florida.

As is the case with Florida, Daytona Beach and the surrounding counties represent an area of critical need. For several years, the VA hospital in Gainesville has been turning away non-service connected disabled veterans because of lack of space. It is conservatively estimated that the use rate of a facility in Daytona Beach would be in excess of 35,000 visits per year. The 12,000 elderly veterans alone in Volusia and Flagler Counties—at three visits per year—would exceed 35,000 visits. With the inclusion of younger disabled veterans, veterans from surrounding areas, and military retirees, a visit figure in excess of 50,000 each year would be a reasonable forecast. As I mentioned earlier, the veteran population in Florida is currently growing by almost 6,000 per month. This coupled with the fact that Volusia and Flagler Counties, the principal areas to be served, have almost 37 percent of their veteran population age 65 or over and are experiencing migration rates into the counties from the 1970 census to the 1976 update of 60 percent and 27 percent respectively, ensures a growing need for adequate health care facilities. Those who have served their country in the Armed Forces are entitled by law to health care services. I believe that the Government has a moral responsibility to meet these individuals' needs where and when they occur in accordance with earlier commitments of support. Demographics indicate that the central Florida area has an extremely high and increasing concentration of veterans.

With this in mind, I'd like to turn for just a minute to a discussion of the legislative history of attempts to have an outpatient treatment facility established in the Daytona Beach area. In each of the last three fiscal years, the House has expressed its desire to see such a clinic become a reality. Despite this fact, absolutely no action—nor even a hint of any action—has been taken by the Veterans Administration to comply with this direction.

In fiscal year 1979 and again in fiscal year 1980, the House Appropriations Committee recommended that the Veterans Administration, from within available resources, lease appropriate facility space for the establishment of an outpatient clinic at Daytona Beach. The VA failed to act on those recommendations. Consequently, in fiscal year 1981, the Appropriations Committee specifically took note of this failure and stated in its report that, "the committee now directs that the clinic be established as soon as possible." The fiscal year 1981 conference agreement also stated that a clinic should be established in Florida, although the language designating its location was somewhat ambiguous. In an effort to once again clarify this matter for the VA, during a colloquy on the floor of the House, Chairman Boland and I established, for the record, the previously expressed intention of the Congress to have the outpatient facility located at Daytona Beach. Despite all of these efforts, the VA has steadfastly refused to move forward expeditiously with this critical project.

In conclusion, Mr. Chairman, I would again like to compliment the members of the subcommittee for undertaking a review of veteran health care needs in Florida. It is deeply appreciated by myself and the thousands of veterans residing in the Fourth Congressional District. All too often in the recent past, our valiant veterans have come to question whether their legitimate needs are truly recognized by the Congress. Certainly, the leadership you and your committee have demonstrated today will serve to indicate to our veteran constituents that the Congress does care. I applaud your efforts and thank you for allowing me to appear before the subcommittee today.

STATEMENT OF D. EARL BROWN, JR., M.D., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS ADMINISTRATION

Mr. Chairman and members of the committee: We are pleased to be here today to provide an overview and discuss, in part, the veteran's health care delivery system in Medical District 12, which is comprised primarily of the State of Florida.

Medical District 12 includes the VA Medical Centers at Bay Pines, Gainesville, Lake City, Miami, and Tampa; supported by Outpatient Satellite Clinics at Jacksonville, Orlando, Riviera Beach, Oakland Park, St. Petersburg and Ft. Myers. An additional Satellite Outpatient Clinic for Pensacola is planned for activation in the Summer of 1984.

I would first like to discuss and compare this Medical District's delivery of health care with the rest of the Nation.

Over the past seven years, the Veterans Administration has experienced a 122 percent increase in its medical care budget and a 17 percent increase in employment. During this same period, the Florida facilities have received a budget increase of 148 percent and an employment increase of 26 percent.

In fiscal year 1981, Medical District 12 had an estimated veteran population of some 1.4 million, which is approximately 5 percent of the Nation's total veteran population. The most reliable basis for future planning will, of course, be 1980 census data. We have until very recently based our projections on 1965–70 migration statistics which we now recognize are no longer valid. Therefore, we are developing interim population assumptions utlizing both agency and consultant resources. These revised figures will be used for planning purposes until the 1980 census data is available.

Looking at current usage, we note that in fiscal year 1981 the rate of applications for care in Florida was 18 percent above national averages. This factor further amplifies the impact of a growing population. The growing demands for services, coupled with the priority system as established by Congress, have resulted in a higher percentage of service-connected veterans being treated by the Florida facilities. As an example, in fiscal year 1981, 61 percent of all outpatients treated in Florida were service-connected, as compared to a systemwide average of 47 percent. However, with fewer medical, surgical, and intermediate care operating beds per 1,000 veterans, Florida treated more patients per 1,000 veterans than the system as a whole in fiscal year 1981.

The above information clearly indicates that we are experiencing a constant growth in the veteran population in the State of Florida which includes a high percentage of service-connected and older veterans. The statistics also show that resources have been allotted to the State of Florida in greater proportions than to the system as a whole and that VA health care facilities in Florida are still providing more care per 1,000 veterans than the system as a whole. However, we recognize that we are not meeting all the demands for care in Florida. That being the case, in an environment of constrained resources, it becomes necessary to apply the priority system set by Congress to determine which veterans are going to be provided care, within a reasonable time frame. Current VA policy provides that when the demand for care is consistently greater than the supply of available VA resources, as is the case in Florida, access to outpatient treatment is to be restricted to the priority levels for which appropriate care can be provided, unless compelling medical reasons dictate otherwise.

This policy applied to the increasing outpatient workload at VAMC Miami led to the posting of a local policy message to restrict outpatient services. The posting was intended to let veterans in the lowest priority levels know that the care provided to them was being constricted. Unfortunately, the posted message was not consistent with the established priority system in Title 38, U.S.C.; and furthermore, it had not been cleared by VA top management.

We recognized that aspects of that directive were in conflict with the provisions of the priority system, and directed immediate removal of and prohibited future use of such documents. Specifically, the document would have restricted access to care of service-connected veterans who were less than 50 percent service connected disabled when seeking care for nonservice-connected conditions, while allowing other veterans with lower statutory priority to receive such care. Access to VA care for any condition of a veteran who is service-connected, but rated less than 50 percent, cannot be restricted unless we have suspended all care to veterans with lower priority, including all nonservice-connected veterans. obviosly, this was not the situation at the time.

The posting was symptomatic of the concerns of the Miami VAMC for providing high-quality care to their patients within an environment of limited resources. This

fact was recognized during the fiscal year 1983 budget hearings held by the Regional Director, in March 1982, and $1 million and 13,500 outpatient staff visits were redirected from other Southeastern VA facilities to Miami. Following those budget hearings, 20,000 outpatient visits and $1 million were also added to Tampa's budget for fiscal year 1983. Since that time we have also finanlized plans to provide 161 additional FTE and more than $5 million in conjunction with completion of the replacement facility at VAMC Bay Pines. Other resource adjustments to Florida facilities in fiscal years 1982 and 1983 are listed in Attachment I to this statement.

The capacity of our health care delivery system is, of course, limited by our physical facilities. Major construction planning and execution are required to significantly alter this capacity. Since 1975 approximately $225 million has been expended to renovate, expand or replace the existing medical care facilities in the State of Florida.

Several major construction projects are currently underway that will improve our health care delivery capacity. Major construction projects are currently in planning for the State of Florida and will be included in the five year facility plan to be submitted to Congress in the near future.

Prior to the passage of Public Law 93-82, which expanded VA outpatient treatment authority, the VA operated clinics at St. Petersburg and Jacksonville. Since that time, we have located clinics at Orlando, Riviera Beach, Ft. Meyers and Oakland Park. The Jacksonville Clinic was relocated into new and expanded space. An additional satellite clinic for Pensacola is planned for fiscal year 1984 activation.

Mr. Chairman, our future planning is structured to fully consider the needs of veterans in the State of Florida. Over a year ago, the Veterans Administration established a "grass-roots" planning process called Medical District Initiated Program Planning (MEDIPP). This process provides for the analysis and consideration of the full scope of veterans' medical care demands to be addressed at a local level. It involves management and program officials at the facility and District level who have been given the responsibility to develop program plans which are comprehensive and provide for health care delivery without sacrificing the quality of patient care. Medical District 12 (Florida) is fully involved in this planning process.

To assist in carrying out this initiative, professional health planners have been assigned to existing staffs in medical districts to work with their executive councils which are composed of district medical facility directors. Planning Boards made up of Service Chiefs—both clinical and administrative—have been established which act in an advisory capacity to the Medical District Director, develop planning proposals and provide support and guidance to the planning effort. These Planning Boards provide a forum to assure input from affiliated medical schools, service organizations and other "consumers". Intrinsic to the design of MEDIPP is the heavy reliance on an assessment and strategic plan for meeting the needs of the veterans in a given district, liaison with local health planning groups and coordination or sharing with other health care providers in the community.

We are also conducting a 30-year study of the health care requirements of Florida veterans as required by Senate Appropriations Committee report language accompanying our fiscal year 1982 appropriations. This study will include the assessment of the need for hospital, outpatient, nursing home and domiciliary care over 10, 20, and 30-year horizons. Models developed by the Department of Medicine and Surgery will be used to determine the requirement for these types of care. These models will include historical utilization of services and incorporate various demographic features specific to Florida. When results are available, Florida's current services and facilities will be examined in order to compare the needs versus current capability to meet these needs.

Various options to address these needs will be explored and a plan developed.

This entire study will be integrated with the Department's new decentralized planning process—Medical District Initiated Program Planning (MEDIPP). The two districts which comprise Florida will be working in conjunction with VA Central Office personnel to prepare this study and the subsequent report of the results to Congress.

All of what I have said indicates that we are experiencing a constant high rate of growth of the veteran population in the State of Florida which includes a high percentage of service-connected and older veterans. We have already taken measures to alleviate, on a short term basis, the effect this growth has had on the health care delivery system in Florida. Long-range methodologies which will address distribution of our limited resources to various regions of the country are in the final stages of development. These methodologies will include consideration of the equity of access to care for veterans in different regions of the country. We believe that through the concerted efforts that are presently underway the MEDIPP process, the

30-year study as well as initiatives by the Southeast Regional Director and other Central Office officials, the Veterans Administration will attain an appropriate and equitable distribution of workloads and resources.

Mr. Chairman, that concludes my remarks. I will be pleased to respond to any questions you may have regarding these matters.

RESOURCE ADJUSTMENTS TO FLORIDA HEALTH CARE FACILITIES

MEDICAL CENTER	FY 82 *	FY 83 **	DESCRIPTION
Bay Pines	33 FTE $717,000 (recurring)		For staffing to build up for activation of replacement facility in FY 83.
		54 FTE $741,000 (non-recurring)	For preparations necessary prior to full activation of replacement facility.
Lake City	3 FTE $86,000 (recurring)		Support for a new learning resources center.
Gainesville	2 FTE $179,000 (recurring)		To assist with the cost of providing radiation therapy.
	1 FTE $26,000 (recurring)		Rehabilitation case manager.
		$16,593	For nurse special pay.
Miami	52 FTE 50,000 out-patient visits $1,340,000 (recurring)		To complete funding of the new Oakland Park Clinic.

Attachment I

MEDICAL CENTER	FY 82 *	FY 83 **	DESCRIPTION
Miami	5 FTE $205,000 (recurring)		To improve Spinal Cord Injury Unit, establish a urodynamics lab and hire a case manager for rehabilitation.
	$776,000		To replace 12 year old linear accelerator.
	$550,788 (recurring)		For nurse special pay.
		$1,100,000	For acquisition of second CAT Scanner
Tampa	$203,000		To replace their ICU monitoring equipment.
	3 FTE $272,000 (recurring)		To assist with provision of radiation therapy.

* The FY 1982 adjustments that we have listed are not meant to be all-inclusive. There were other additional, routine adjustments that were made such as wage grade increases, funding of the GS pay raise, additional fuels and utility funds, and fee basis funds which have not been enumerated.

** Forty-five additional FTE have also been included as an adjustment in the budgets of the Florida medical centers.

STATEMENT OF MR. TOM DOHERTY, DIRECTOR, VA MEDICAL CENTER, MIAMI, FLA.

As an introduction to my testimony, I would like to present some background information. In 1968 the hospital moved from the old Biltmore Hotel in Coral Gables to a new facility. While the new hospital was under construction, it was decided to increase the bed capacity from 700 to 1,000 beds. This was accomplished by adding extra floors to the patient care tower. No provisions, however, were made for expansion of the support areas. There were no intensive care units, inadequate storage and warehouse space, insufficient radiology rooms, no education or research space and a ridiculously small area for outpatient/ambulatory care treatment. Consequently, the intensive care units were carved out of patient bedrooms and did not meet criteria; storage was maintained in hallways and offices and eventually a warehouse had to be rented 12 miles away. The outpatient area, built for 135 patients a day, was seeing 1,000 patients a day and several inpatient areas had to be converted to support Mental Hygiene Clinic, Day Treatment Center, Ey Clinic, etc. Throughout the hospital patients were waiting in hallways and corridors to receive treatment.

Unfortunately, staffing for support services was never adequately funded either, and the history of the Miami Medical center from 1968 has been one of catch up from its original shortcomings in the face of an ever expanding workload.

The expanding workload is of course directly related to the migration of population into the Miami Medical Centers Primary Service Area. The service areas consist of the Southeastern 10 counties of the State. In 1970 there were 2,464,000 people in the ten counties of which 344,000 (approximately 14 percent) were veterans. The 1980 Census population data showed that there were 3,611,991 people in the area. This is a 46.5 percent increase in just ten years! This means that over ⅓ (actually 37 percent) of the entire population of the State of Florida live in the Miami Medical Center's service area!

In addition, the South Florida population contains a larger than average number of people who are over age 65. The National average is 11 percent but South Florida is at twice that level. Consequently, the Miami Medical Center is responsible for the care of a very large number of eligible veterans, a high proportion of whom are elderly, with multiple problems, including chronic disease. As the bulk of the veteran population continues to grow older, the amount of care needed by this group will increase dramatically since they use medical services at a much more frequent rate.

The Miami VA Medical Center is the only VAMC in the Southeastern portion of the State. There are four other VA Medical Centers located in the West and North Central parts of Florida. The nearest of these is 250 miles away. Consequently, there is no viable alternative to the Miami VAMC for the majority of the veteran beneficiaries in the Southeastern portion of the State.

Much has been done to solve the problems that the Miami Medical Center has faced in coping with the veteran workload. In 1976 an outpatient clinic was opened at Riviera Beach, Florida, approximatley 75 milies north of Miami. It now operates at 50,000 staff visits per year. In January of this year a new outpatient clinic was opened in Oakland Park, at 65,000 staff visits a year. These two clinics have helped reduce some of the strain on the outpatient facilities at Miami. A planned 49 million dollar Ambulatory Care Expansion project is scheduled to start in early 1983. This will allow the Medical Center to solve all of the space problems associated with its outpatient programs. In 1980, a 120 bed nursing home was completed. This allowed the movement of nursing home patients out of the main hospital building. In 1984 an additional two stories are planned for another 120 beds to cope with increased aging veteran needs. In November 1982 the first three stories of a planned 6-story Research & Education Building will be completed. After the first 3 stories are complete, approximately ½ of the VA research functions presently located in the main hospital building and in trailers located on the VA grounds will be relocated. The additional 3 stories planned for fiscal year 1987 will house the remaining research functions so that the entire research operation can be located in one building allowing the vacated space to be used to correct shortages of space in Radiology, Supply Processing, Nuclear Medicine and the Medical Center Computer Facility. A project to construct a modern surgical intensive care unit will be completed in the July of this year. Another project to renovate and update the medical intensive care and coronary care/units is planned for fiscal year 1984.

These projects, and their associated equipment and staffing, will allow the Medical Center to continue its quality health care to the veterans of Florida. The problems, however, are not likely to be completely solved for some time to come. Although the total veteran population in the Nation is expected to decrease by 10 percent in the next 20 years, the State of Florida is expected to have an increase in

veteran population. This increase will continue to put a strain on all of the VA Medical Centers in the State. These Medical Centers have for years lacked long term psychiatric beds, sufficient nursing home beds and adequate outpatient visit funding. These programs can reduce the number of acute beds needed by taking the veteran patient out of the expensive hospital bed and caring for them in a less expensive but equally effective modality. The acute beds can then be used for patients who require the sophisticated and specialized care provided in this type of setting.

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to express its views and concerns on hospital care and medical services which are provided by the Veterans Administration to veterans in the State of Florida. PVA has a large concentration of members who reside in Florida and has three separate Chapters located in South Florida, Tampa Bay, and Orlando.

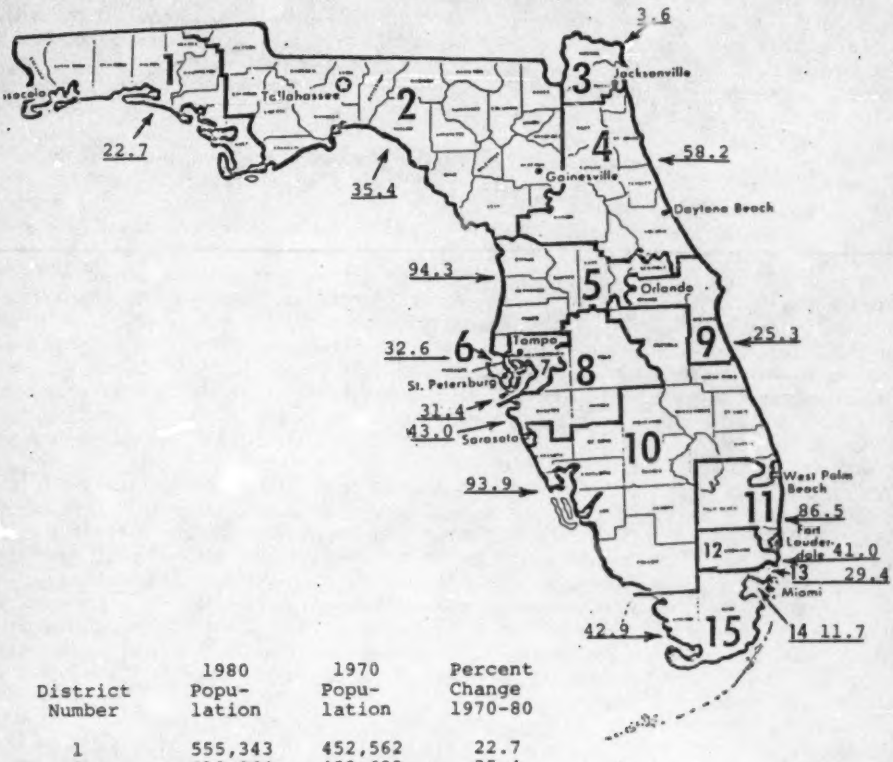
PVA believes that a unique situation exists in the State of Florida regarding the veteran population and its need for the services provided by the VA health-care system. Florida is located in the Sunbelt area, which is experiencing large increases in population. Florida is among the three fastest growing states in the nation. The recent 1980 Decennial Census Report indicates that the state's population increased by almost one-half in the period from 1970-1980. A population of 6,791,418 in 1970 reached 9,789,992 in 1980, a 43.4 percent increase. This figure is compared to a national increase of 11.4 percent. Florida is currently ranked as the seventh largest state in total population, and projections based upon the 1980 census indicate that it will rank fourth in population by 1990.

To highlight the importance of these numbers it might be illustrative to point out the changes occurring in Congressional Districts within the State of Florida. The most immediate result of the population influx during the decade 1970 to 1980 was that Florida gained a total of four additional Congressional seats due to reapportionment. This increase was the largest gain of Congressional seats by any state in the nation. The "ideal district" population for the state increased from approximately 452,500 to 512,631 (an increase of more than 60,000 people per district). The percent change per district during 1970 to 1980 ranged from a low of 3.6 percent to a high of 94.3 percent. Four districts increased at a rate higher than 50 percent; 10 districts increased at a rate higher than 30 percent, and 13 of the 15 existing districts increased at a rate greater than 20 percent. These figures are based on Census Data indicating an average of 24,571, persons moving to Florida each month during the period 1970–1980. Estimates of the number of veterans moving into Florida each month during the same period vary from 5,000 to 7,000: current estimates of the continuing rapid increase of the veterans population in the state are 3,000 to 5,000 per month. Consider the effect on delivery of VA health care services in any state if 25,000 individuals, of which 5,000 were veterans were flooding into that state month after month and year after year. PVA has prepared a map of Florida with figures showing the actual increase by Congressional District and the distribution of population increase by percentage, to better illustrate these facts.

POPULATION INCREASES

IN THE STATE OF FLORIDA

1970 - 1980



District Number	1980 Popu-lation	1970 Popu-lation	Percent Change 1970-80
1	555,343	452,562	22.7
2	612,964	452,633	35.4
3	469,156	452,841	3.6
4	715,027	452,076	58.2
5	880,078	452,965	94.3
6	600,086	452,615	32.6
7	595,159	452,820	31.4
8	646,104	451,776	43.0
9	567,309	452,923	25.3
10	878,067	452,848	93.9
11	843,299	452,170	86.5
12	638,897	453,053	41.0
13	586,114	452,817	29.4
14	505,623	452,663	11.7
15	646,764	452,681	42.9

PVA believes that it is important to note that present projections indicate that Florida's veteran population will double by the end of the century while the national population will be decreasing by almost 10 percent. This fact means that Florida's present unique status and problems with regard to VA health-care delivery will be further aggravated if prompt planning and expedited actions are not taken immediately.

There are 1,369,000 veterans in Florida, which make it the seventh largest in terms of total veteran population. However, Florida ranks third in the nation in the percentage of veterans to total state population. And, it is interesting to note that the two leading states in this respect are Rhode Island and Washington, with total veteran populations of 153,000 and 617,000 respectively. Florida also has the seventh largest total population of wartime service veterans with 1,208,000 individuals in that category.

A major factor in Florida's unusual requirements for VA health-care services is the composition of the state's veteran population. The percentage of veterans over age 65 is already higher than the national average. VA projections, based upon available data, foresee a five-fold increase in the number of veterans aged 65 to 74 residing in Florida by the year 2000. There is also expected an eight-fold increase in veterans over age 75. The projections of older veterans in Florida are more than double that expected on a national average for aging veterans. This projection makes it imperative that VA planning for future services include adequate provision for geriatric care. The aging veteran population in Florida will require resources to provide sufficient out-patient and in-patient care to these elderly veterans with their specialized medical needs. Also, planning for construction for long-term care facilities and nursing home units must be started or accelerated immediately if adequate health-care services are to be provided in a timely manner. This requirement may become especially critical if the aging veteran is single or survives his spouse and has no family or personal resources to provide for his care. And, it is especially important that planning and action begin now, to provide the needed facilities because VA information indicates that there is a greater demand for VA health care by the over 65 age group for both in-patient and out-patient treatment. Aging veterans require four times more in-patient treatment and two to three times the out-patient treatment of veterans under age 65. Also, the Florida population includes a high percentage of disabled veterans. With the increasing population and age of veterans projected for Florida it is anticipated that the VA will be forced to deny VA health-care services to some veterans in higher priority classifications, unless additional services are made available.

Another problem which must be addressed is the need for the VA health-care system to adequately provide for the female veteran. A VA study has found that women who are former members of the U.S. armed forces numbered 742,000 as of September 30, 1981. This number represents 2.5 percent of all living veterans. The study also indicates that the number of female veterans has increased by 26 percent in the past five years. Current expectations are that the number of women in the armed forces will very likely continue to grow by significant numbers. The expected result is that the female veteran population will grow steadily in future years. The study showed that as of September 1981, the median age for female veterans was 46.2 years as compared to 50.3 years for male veterans. These statistics have implications which must be addressed by the VA on a nationwide basis. But, probabilities that a large number of female veterans may now be, or may become, residents of Florida should also be addressed in planning for the VA's role in providing future health care services in that state.

One other factor to consider during the planning process for future requirements is that Florida has an annual population increase of "seasonal residents". These individuals are those who own or rent some type of second home in Florida and spend the winter months in residence there. This semi-permanent population contains a proportionate number of veterans who require Va health-care services which must be provided during the veteran's extended stays in Florida. This factor has placed a special burden on the requirements for VA services and must be adequately addressed in providing for current requirements and in planning for the future needs of Florida's veteran population. The result must be that VA facilities will be prepared to provide the necessary services to eligible veterans who are part-time residents of the state, as well as maintaining the level of care for permanent residents.

Another unique aspect to consider in regard to Florida's current and projected veteran's population is the status of the non-service-connected disabled veteran. These individuals are not being treated on an equal basis with veterans of the same status or classification, because they live in a state where the large veterans population has over-taxed the capabilities of the existing VA health-care facilities. The

large veterans population compared with the existing facilities means that only those veterans with the higher classifications for priority of treatment are being treated by the VA. Approximately 45 percent of Florida's veterans are service-connected with 30 percent on a national average.

This situation is exacerbated when the influx of seasonal residents occurs, and a larger number of higher-priority veterans seek VA health-care for which they are eligible. This means that during many months of the year the Florida NSC veteran is placed further down on the eligibility list for VA treatment. PVA does not argue that uniform classifications of eligibility for health care treatment should exist. But, we do say that the application of these priority ratings works an undue and unequal hardship on Florida veterans. The uniform application of eligibility standards assumes a uniform availability of health care services and facilities which do not exist in the Sunbelt states that experience an influx of seasonal residents. This principle does not apply to the veterans of Florida or the other Sunbelt areas because of their singular situation.

As has been pointed out, many NSC veterans have provided lengthy valuable service to the nation. Consider the veterans who volunteered for service in World War II and spent the duration of the War in the armed forces, and who, perhaps, was called back for service during the Korean Conflict. The degree of disability of NSC veterans should also be considered in the fair application of health-care priority classifications. The catastrophically disabled spinal cord injured veteran has a need for uninterrupted health care services. Is it just or equitable that such a veteran is denied treatment, or has his treatment interrupted on a seasonal basis, because of the lack of VA health care facilities in Florida? Or, should such a veteran be forced to remain in another location and not be able to relocate to Florida because VA services would not be available when such a move would allow him to more actively enter the mainstream of daily living and, perhaps, even prolong his life?

A special feature which must be addressed when considering VA health care services in Florida is its geography. The state's unusual configuration is that of a 400 mile long peninsula between the Atlantic Ocean and the Gulf of Mexico, with the Florida Keys extending 110 miles south of the mainland to Key West. The distance of approximately 400 miles across the northern width of the state from Jacksonville to Pensacola also contributes to Florida's special geographical make-up. The long stretches of coastline on the Atlantic and the Gulf Coasts make Florida unlike most other Sunbelt areas. The availability of large areas near the water has contributed to the existence of many significant areas of population growth whereas other Sunbelt states have found the increase in population to be concentrated in certain limited areas within the states. This distribution of population is also shown on the map provided above. This must be considered when providing for present and future needs of the state's veteran population because veterans must often travel significant distances to reach available VA health-care facilities, a factor which is especially important to the catastrophically disabled SCI veteran who must use special transportation facilities.

As stated earlier, PVA has a large concentration of members in the State of Florida (approximately 7.5 percent of total PVA membership). Also, Florida has special features to attract additional SCI veterans in the future. The climate is attractive to the SCI veteran because of the absence of restrictive winter conditions which exist in more northerly states. These veterans who must use wheelchairs for mobility are not house-bound as often happens during snowstorms or during freezing weather conditions. This restriction in other areas occurs either because of an inability to use a wheelchair in such conditions or because of health dangers associated with spinal cord injury. Added to the attractive climatic conditions are the accessibility features of the state. Few areas are more physically accessible to wheelchair users. This accessibility is in many respects attributable to the architectural development in the state. Many homes, office buildings, stores, shopping centers, and recreational facilities have traditionally been built on on level. Also, due to the large number of elderly residents, other features of accessibility exist. Special efforts have been made in many areas of the state to provide for the unique needs of SCI veterans and other disabled individuals. Transportation, employment, and recreation facilities are readily available in many areas of the state. These factors lead PVA to believe that a proportionate increase in SCI veterans can be expected to relocate to Florida.

The present large number, and the expected increase of SCI veterans, requires prompt action by the VA to provide for their health-care needs. Florida is currently the second largest state in number of SCI veterans treated by the VA. There are currently two designated SCI Centers in the state, which are located at Tampa Veterans Administration Medical Center and Miami Veterans Administration Medical

Center, which provide both out-patient and in-patient care. PVA is especially concerned about the present and future capability of the SCI Center at Tampa VAMC to fulfill its assigned mission. This unit has 42 operating beds and is currently overutilized, according to VA SCI Service information. The unit now works at or within 1 bed of 100 percent occupancy on a daily basis. The unit is overcrowded and has a continuous waiting list for patient admission. This is especially significant for SCI patients who require continuous medical care, including regularly scheduled medical checkups, to ensure that problems are diagnosed before they become critical and possibly life-threatening. When emergency situations develop, as they continuously do with SCI patients, the overcrowding becomes especially crucial. Often, less seriously ill SCI patients must be moved out of the SCI unit to wards where the personnel are not experienced in dealing with the patient's special medical needs. And, emergency admissions mean that patients scheduled for admission must be abruptly notified of cancellation and re-scheduling. This can be especially frustrating for catastrophically disabled veterans who have special travel problems which must be arranged in advance. Also, the problem is further aggravated when SCI veterans must plan to travel long distances, as is often the case in Florida. PVA understands that existing plans for expansion of the SCI unti at Tampa require expansion to 100 beds by 1985 or 1986. This means that the already existing overcrowding will continue and undoubtedly be further aggravated because the proposed expansion is meant to fulfill projections which are already proved to be inadequate.

PVA has been informed of other problems with the VA health-care system and the services it provides to Florida residents. A continuing problem is the recruitment and retention of trained nursing-care personnel. Due to the large number of elderly residents, the huge total population, and its rapid increase, all Florida health-care facilities are continuously seeking qualified nurses. The ability of the private sector to provide higher pay, more comprehensive benefits, and flexible working hours adversely affects the VA's ability to recruit and retain nursing care personnel. PVA has addressed this topic in previous testimonies where we pointed out that this situation is especially harmful to the staffing of SCI wards. Due to the medical condition of the patients, nurses are called upon to provide more intensive, time-consuming and rigourous care. PVA believes that the dedicated nursing care personnel who serve in SCI Centers should be compensated accordingly. Also, PVA hopes that the Chief Medical Director will quickly act to implement special incentives such as premium pay for Saturday work and use of the "weekend alternative," Baylor Plan, in Florida as soon as these additional recruiting and retention aids become available.

Other critical areas of health-care to SCI patients are the timely and adequate provision of medical supplies and pharmacy items. PVA understands that some medical supplies necessary for the daily ue of veterans are being restricted or denied solely due to budgetary considerations. Information also indicates that the provision of medications through pharmacy services at Florida's VA hospitals are being delayed for the same reason. The catastrophically disabled veteran is often dependent upon continous medications. The usual procedure is to re-order these prescriptions on a monthly basis. PVA has received indications that on occasion the refilling of active prescriptions is delayed for one week each monthly period. The net result is that over a year's time the pharmacy is able to eliminate one complete month in a year's supply of prescriptive medications. Obviously, under existing circumstances, Florida's veterans are not receiving the best possible health care from the VA. Nor, apparently, can they expect such care for a number of years if current practices persist.

The VA must act immediately to provide for the present and future needs of Florida's veterans. These veterans deserve to be treated on an equal basis with veterans residing in other states. VA personnel have indicated that services to higher priority categories of veterans in Florida will have to be denied unless additional resources are made available. The first requirement is for more operating beds for VA facilities in Florida. Some projections indicate the need for approximately 2,400 additional beds by the year 1990. Careful study must be made to include the correct distribution of any additional authorized operating beds. Consideration of the composition of Florida's veteran population, with emphasis on the aging veteran, must be made. The "mix" of acute care, sustaining-care, and long-term care beds must be compatable with the make-up of Florida's veteran population. PVA believes that there should also be a concommitant increase in the number of nursing home beds. Special consideration should be given to the geographical distribution of these additional beds giving due regard to present and projected population growth within the state.

As was pointed out, Florida's growth has been unique because of its geography, and PVA specifically requests that construction begin as soon as possible on the expansion of the Tampa VAMC SCI Center. Sufficient justification for this project already exists. In fact, PVA believes that the present facts justify any and every effort to expedite this project, and we urge the VA to give it the highest priority.

PVA also believes the needs of the aging SCI veteran must be addressed in planning for VA health-care delivery in Florida. In the "PVA Response to Spinal Cord Injury Program Plan Fiscal Year 1980–1987", dated March 15, 1980, PVA noted that the VA proposed to expand the SCI service nation-wide from 18 centers with 1,386 beds to 23 locations with 1,565 beds. On a level of care breakdown this would provide 236 beds (15 percent) for intensive rehabilitation, 845 beds (54 percent) for sustaining care and 484 beds (31 percent) for long-term care. PVA concurred that as increase in SCI beds was required and PVA has supported an increase in the percentage of long-term care beds from approximately 25 percent of total SCI beds to the projected level of 31 percent of total beds. This support reflects PVA's realization that, as the SCI veteran population ages, the need for long-term care beds will increase. PVA now requests that the special needs of the aging SCI veteran in Florida be specifically included in planning for future VA facilities.

PVA's Research Program has been working with Dr. Juan Fonseca, VA Director of SCI Service, on developing current information of the SCI veteran population. The information as it becomes available, and projections based upon this information should greatly assist the VA in this area. PVA believes that expansion of the current out-patient treatment facilities should be addressed in planning for present and future VA health care services in Florida. VA projection indicate an expected large increase in the number of outpatient visits.

PVA urges that consideration be given to the establishment of additional satellite clinics for out-patient treatment. This recommendation is based upon the abovementioned large population increses in all areas of the state. Also, the special geographical features of Florida must be considered as they impose a requirement for travelling long distances to reach VA facilities. The facts should be specifically, related to the large aging veteran population which is projected to increase at a greater rate than the national average. PVA urges that the inclusion of SCI outpatient clinics be considered when planning for these proposed satellite facilities. Special SCI clinic days at these facilities with appropriately trained SCI health-care personnel available would alleviate some of the special problems of travel associated with SCI patients.

The needed increase in resources must include sufficient increase staffing to properly treat Florida's veterans. This requirement includes not physicians and nursing-care personnel, but, also, urgently needed support staff required to provide the best possible medical care. PVA hopes that areas such as pharmacy services are specifically considered. Many of the problems in this area can be attributed to a lack of sufficient staff to meet current demands. Hopefully, the Administration's decision to allow individual stations to purchase computer equipment may also serve to alleviate the problem. And, once again, PVA points out the difficulty in recruiting and retaining qualified nursing care personnel especially in SCI units where the workload is time consuming and rigorous.

When discussing staffing, PAV wishes to point out the special need for sufficient VA Department of Veterans Benefits personnel in Florida. This is especially important because current Administration policies call for reductions in this area on a nation-wide basis. Florida's special problems (a large veteran population and a continuing influx of new veterans) require sufficient personnel to process records in a timely manner. PVA believes that the seasonal increase in veteran population also provides a unique problem for DVB personnel who must not only deal with the increased numbers but also with the special problem of transferring records back and forth on an annual basis, or using an alternative solution to handle the problem. The timely delivery of health-care services in Florida now, and in the future, requires that the state's special problems be addressed in all VA services. Mix-ups or delays in providing information in VA records to health care facilities must be avoided.

PVA recommends that Florida be given priority status in developing VA–DOD Sharing Agreements. Florida is also a unique state in regard to the number of existing DOD facilities and their geographical distribution. PVA believes that the establishment of sharing agreements in Florida on a priority basis may help solve some of the existing problems in the provision of VA health-care services. Also, future planning should include such agreements as an integral part of the overall delivery of health care to Florida's population.

PVA also believes that special attention should be given to medical research in Florida's VA facilities. We have testified on this subject previously and pointed out that availability of research funds and facilities are an important factor in attracting and retaining highly-qualified VA physicians. This area is of special importance in a state where private health care providers are actively seeking qualified doctors. PVA has urged that funding levels for all VA research be increased to assist in recruiting and and retaining highly trained personnel. The impact of research allocations to VA facilities in Florida should be a part of the planning for future capabilities of that state's VA hospital care and medical services to veterans.

Mr. Chairman, PVA believes that immediate action must be taken by the House Veterans' Affairs Committee to provide sufficient resources now and in the future to adequately care for Florida's veteran population. We have already seen this year the need to provide supplemental funds to VA facilities in Florida to enable them to continue to treat service-connected veterans. If these additional funds had not been made available on June 1, 1982, these veterans would have been denied VA health care in certain circumstances. Another reason for the immediacy of the situation is the rising concern of the veterans population about the VA's desire to fulfill its assigned mission. Much of this concern is directly related to Administrator Robert P. Nimmo's continuing tales of lack of resources as expressed in the media. PVA alluded to this problem in its annual testimony before the House Veterans' Affairs Committee on March 2, 1982. We pointed out that reports in national magazines seemed to indicate an anticipated failure of the ability of the VA health-care system to meet its obligation to provide the best possible care to eligible veterans. This situation has been exacerbated since that testimony. For example, in a June 1, 1982 article in U.S. Medicine there is a report that Administrator Nimmo has indicated that if some fiscal year 1983 Budget proposals were accepted the VA health-care system would be forced to cut personnel by 6 percent next year and the reduction required by 1985 would be 15 percent. Alternatives expressed by the Administrator were a 21 percent cut in outpatient workload or a 6 percent cut in inpatient workload. Other possibilities expresed by the Administrator included medical facility closures. Yet, PVA asks, where was Mr. Nimmo when these budgetary restrictions were being considered and what was he doing to counter them? Examples such as these are sure to increase the frustration of veterans nation-wide, and especially in a state such as Florida where VA health-care facilities are sufficient for the present veteran population. PVA hopes that the actions of this Subcommittee and the full Committee will allay some of the concern felt by America's veterans.

Mr. Chairman that concludes my testimony. I will answer any questions that I can.

STATEMENT OF CHARLES E. JOECKEL, JR., DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the subcommittee; on behalf of the 720,000 members of the Disabled American Veterans, particularly those of our membership who reside in Florida, I am pleased to appear here today to discuss the provision of hospital care and medical services provided to veterans in the State of Florida and to express our views on H.R. 6401—a bill to require the Administrator of Veterans Affairs to consider the number of veterans residing in each state in acquiring the operating medical facilities.

As you know, Mr. Chairman, Florida is one of the fastest growing states in the nation. From 1970 to 1980 the overall population rose from 6.7 million to 9.7 million, an increase of 43 percent in ten years. Today, Florida is the seventh largest state in the United States in both total population and veteran population. It is projected that by the year 2000 the Florida veteran population will increase from 1.3 million to 2.6 million, an increase of 100 percent. According to VA statistics, over this period the overall veteran population will drop from 30 million to 27 million, a 10 percent decline.

Without a doubt, this increasing veteran population in Florida has resulted in a significant increase in demand for VA health care. In addition, the makeup of the veteran population in Florida includes a high percentage of aged veterans.

According to information we have recently received, in Fiscal Year 1981, 15.4 percent of veterans seeking medical care in Florida were 65 years or older—this compares to 11.7 percent of VA patients nationwide. It is projected that by the year 2000 there will be a 550 percent increase in veterans age 65 to 74 and a 775 percent increase in veterans over the age of 75. Although Florida's veteran population is older, 44.4 percent of its veteran patients are service-connected, compared with 33

percent nationwide and 15.3 percent are in receipt of Aid and Attendance and/or VA pension benefits, compared with 13.8 percent nationwide.

According to the Veterans Administration, their facilities in Florida now handle a higher percentage of priority outpatient visits than any other VA medical district in the nation.

Our concern, Mr. Chairman, is whether or not the VA will be able to continue to provide care to all service-connected disabled veterans in Florida. Given the tremendous growth in the veteran population in the State of Florida, can the VA meet its obligation to service-connected disabled veterans without increased resources?

In a recent meeting with the Florida Congressional Delegation, the VA outlined some of its planning currently underway to meet Florida's growing demand for VA health care.

For example, the VA has added $1 million and 13,500 outpatient staff visits to Miami's budget allocation beginning in fiscal year 1983. Twenty full-time employees are being added to the staff. The outpatient clinic in Miami, originally designed to handle 135 patients daily, currently serves 850 veterans a day. To alleviate some of this burden the VA is planning the construction of a $49 million Ambulatory Care and Spinal Cord Injury Unit and the Agency is planning an expansion of the Radiology Department at Miami.

While Florida has no long-term psychiatric facility, the VA reported that a new addition, which will include 200 long-term psychiatric beds, is being planned for construction at Gainesville. According to the VA, the construction of a new Spinal Cord Injury Unit at Miami will enable the VA to establish 42 additional psychiatric beds at the Miami VA Medical Center.

In order to improve efficiency in its hospitals, the VA plans to have a new system in place by 1983. Due to staffing shortages, the Nursing Home Facility at Miami has only 90 of its 120 beds available to veterans in need of nursing care. In the very near future, funding and staffing are to be made available in order to make full use of the 120 bed capacity at that facility. The VA also stated that an additional 120 bed Nursing Home Unit is being planned for construction at Miami to be completed in 1986.

Mr. Chairman, the DAV is pleased to support the VA's current plans to expand and improve its facilities in Florida. Yet, we remain concerned about VA's ability to meet its increased demand for health care services.

As you will know, fiscal restraint, which had been imposed upon all federal agencies and departments, dictates whether the resources will be available for the VA to meet it obligations not only in Florida but throughout the nation.

H.R. 6407

Through appropriate amendment of Section 5002 of Title 38, U.S. Code, this measure proposes to require the Administrator of Veterans Affairs to consider the number of veterans residing in each state, and the projected changes in the number of veterans residing in each state, in acquiring and operating medical facilities.

Essentially, the measure would require that each Fiscal Year the Veterans Administration:

Analyze Agency-wide admission policies and the records of those eligible veterans who apply for hospital care, medical services and nursing home care of veterans who are rejected for such services;

Review the adequacy of the capacity of medical facilities, the adequacy of established operating bed levels, the geographic distribution of operating beds, the number of veterans residing in each states at the end of each Fiscal Year, the change in the number of veterans residing in each state during each Fiscal Year, the projected change in the number of veterans residing in each state, the demographic characteristics of the population of veterans, the associated need for medical facilities and medical care in each state, and the proportion of total number of operating beds that are hospital and nursing home beds; and

Make reommendations to the Administrator based upon the review of these criteria.

Mr. Chairman in our view, the enactment of H.R. 6401 would put into statute and formalize a policy which we believe has been, to a large degree, in effect at the Veterans Administration for some time.

Over the past four months the DAV has received several briefings concerning the progress of the VA's Federal Planning and Construction Committee (FPACC). According to a VA Discussion Paper dated March 19, 1982, FPACC was created to review 57 construction projects and to establish "defensible and accurate criteria" for the construction of VA medical facilities.

The guidance to FPACC Steering Committee given by VA Memorandum dated March 17, 1982, contains many of the instructions outlined in H.R. 6401. For example, the Memorandum calls for the review of the veteran demographic data used, as well as bed allocations and workload projections.

Over the past few months it has become clear that the VA already used the criteria outlined in H.R. 6401 for the planning of medical construction projects. We believe examination of VA's criteria and its planned construction of the 57 facilities will indeed result in the revalidation of these projects.

While the DAV has no specific mandate regarding the provisions contined in H.R. 6401, we believe that the enactment of this measure would clarify the criteria used in the planning and construction of its facilities. In addition, facility construction projects approved under the guideline contained in H.R. 6401 would eliminate the need for further justification and continued validation of VA construction projects.

This concludes my statement, Mr. Chairman, and I wish to thank you and the members of the Subcommittee for allowing us to present our views on these important subjects.

STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the subcommittee, thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

The large shift in population to the Sun-Belt States is a recent phenomenon. With respect to veterans, the State of Florida has been the hardest hit. In September 1978, the veteran population in Florida as reported by the Veterans Administration totaled 1,279,000 and by September 1981 that figure had increased by 118,000 for a total of 1,397,000. This represents a monthly increase of 3,277 veterans which has caused an unanticipated demand for medical care by primarily an aging-veteran population.

In testimony earlier this month before the Senate Veterans' Affairs Committee, the Chief Medical Officer of the Veterans Administration Outpatient Clinic in Fort Myers, Florida, painted a very graphic and highly disturbing picture. On that occasion Dr. Gilbert Houston stated in part: "As the population and age of veterans increase, we in the State of Florida will be forced to deny VA care to some veterans in high priority categories unless additional resources are made available.

"The inability to provide VA care to service connected veterans, the highest priority group, in the foreseeable future is a possibility. The VA health care delivery system could certainly adapt to meet the current and projected health care needs of Florida's veterans but this can be accomplished only with increased resources.

"The clinic opened November 5, 1979. It is a satellite of Bay Pines and refers approximately 95 percent of its admissions and consultations to that facility. Emergent cases are hospitalized in local non-VA hospitals. Approximatley 3 percent go to Tampa VA and 2 percent go to Miami VA.

"The clinic was programmed for 18,000 visits with 45 FTEE in fiscal year 1980 and realized 23,806 visits. The fiscal year 1981 was programmed for 25,000 and realized 26,065 visits. The fiscal year 1982 workload is equal or greater than that of fiscal year 1981."

Mr. Chairman, our Field Representative Lynn W. Illgen recently surveyed the VA Medical Centers at both Lake City and Bay Pines, Florida. Extracts of those reports follows:

LAKE CITY VA MEDICAL CENTER

"Contrary to projected expectation, there is an unusual balance in the growth patterns percentage-wise across the State. The primary service area for the Lake City VA Medical Center covers a veteran population of about 207,787 in 17 Northern Florida and 19 Southern Georgia counties. The service area covers a rural expanse of sparse population where industrial development and economic growth have been slow. It is interesting to note that there are several counties in Northern Florida and Southern Georgia that do not have a physician practicing or a clinic of any type available. A large number of the elderly veterans who reside in this service area are economically deprived; and public funds or services are not available to care for

their immediate medical care. It is reported that special studies and forecasts reveal that this area is the new frontier of the Sun-Belt.

"An upward trend in outpatient visits continues. For the past three years, the assigned outpatient workload has been exceeded by approximately 3,000 visits and it is expected that this trend will continue because of conditions as indicated in the preceding paragraph.

"A major construction project tentatively approved is the $6 million outpatient and clinical addition. This project is one of 56 in the Veterans Administration scheduled for revalidation. The preceding paragraphs contain sufficient information to justify approval and funding for construction as planned.

"The present 40 bed Nursing Home Care Unit is totally inadequate. Space and accommodations are crowded. The area now occupied has actual space for only about 30 beds. Waiting list for admission to Nursing Home Care Unit—57. Construction of a new 120 bed Nursing Home Care Unit is scheduled for fiscal year 1983. This is a vitally needed project that should under no circumstances be deferred . . .

"Although the Gainesville VA Medical Center has been tentatively approved for construction of a 200 bed psychiatric hospital, the Lake City facility continues without a single psychiatric bed. At least 20 acute psychiatric beds could be well utilized providing adequate staffing is made available. Because of the growing veteran population in the State of Florida coupled with the aging World War II veteran, it is inevitable that in the not too distant future, additional long term psychiatric beds and nursing home care beds will be vitally needed."

BAY PINES VA MEDICAL CENTER

"Since the last survey by this representative, many noteworthy construction projects have increased the operational capability to a degree of uppermost recognition in the entire State of Florida. A new 120 bed Nursing Home Care Unit was officially opened on April 16, 1973. This Unit was the first in the VA system to be planned and constructed as a separate structure for service as a nursing home. Up to that time all other similar facilities in the system were converted structures. It served as a model and pilot for additional VA Nursing Homes opened in Alabama and California in later years. A new two-story clinical support building located between Buildings #1 and #22 was constructed and opened on June 13, 1977. This provided needed additional space for Dental, Laboratory, Nuclear Medicine, Orthotics Laboratory, a Conference Room, a Medical Library and an Eye, Ear, Nose and Throat Clinic. Progress continues.

"Bay Pines is now in the midst of another major construction project estimated at $110 million which will provide for a 520 bed replacement hospital. Part of this project has been completed which included an additional 120 bed Nursing Home Care Unit connected to the Nursing Home Care Unit mentioned in the preceding paragraph. Both units have huge patios overlooking Boca Ciega Bay and each has large activity areas. A very attractive 200 bed domiciliary, also in this project, was completed and opened last year.

"The tentative month of completion of the replacement hospital is November 1982 with Opening in February 1983. Dedication is scheduled for March 1983 in order to combine the Dedication Ceremony with the 50th Anniversary of Bay Pines. The first patient was admitted on March 20, 1933. The third phase of this project includes renovation of Buildings #1 and #22 and demolition of all temporary buildings. Most of the old buildings are structurally sound. Psychiatric patients now in very depressing wards in Building #37 will be moved to Building #1 when renovated.

"The Medical Center's primary service area consists of 18 counties with a total veteran population of almost 346,995 and migration patterns show a 4 percent per year increase. The majority of patients served reside in Pinellas County where the center is located. This medical center is a major part of the community and is among the largest employer and the largest federal employer in Pinellas County. The average age of hospital patients is 61 years, which is older than the average age of veterans nationally. The rate of service connected veterans treated at Bay Pines, includes the two clinics, is 60 percent . . .

"This station is the clinic of jurisdiction for all outpatient activities in the State of Florida and the largest fee basis program in the Veterans Administration with an annual cost of about $15 million. All fee basis cards are issued at this station. There are presently 19,500 active fee basis cards that will generate about 120,000-plus visits this fiscal year. The cumulative average daily patient census for non-VA hospitalization is 33.5. Average daily patient census in community nursing homes is running at 150. All beneficiary travel is expected to reach $570,810 this fiscal year.

"The Ambulatory Care Clinic in St. Petersburg will be relocated at the Bay Pines facility when the new hospital is activated. The very active Fort Myers Outpatient Clinic had a total of 15,152 staff visits as of April 23, 1982."

Mr. Chairman, according to the Veterans Administration "Summary of Medical Programs", the average daily census for the five hospitals in Florida has fallen from 82.5 percent the first six months of the fiscal year 1980 to 79.9 percent for the same period in the current fiscal year. The average daily census for all 172 hospitals has remained quite level at 80.9 and 80.5 percent respectively. Permit me to state at this point the VFW views the VA bed occupancy rate as programed to meet budgetary constraints. We believe this since the average daily census has not fluctuated more than a couple of percentage points either side of 80 percent, whether the VA operated 110,000 beds or 80,000 as they do now. Granted, advances in medical science have shortened hospital stays and the ambulatory care program has, indeed, obviated the necessity for hospitalization in many cases. However, during the period in which operating beds have been reduced by 30,000, we have added 8.5 million veterans of the Vietnam-era and more than one-third of the veteran population consists of veterans more than 60 years of age.

Outpatient statistics are interesting to say the least, Mr. Chairman. Again, using the first 6-month figures of 1980 and 1982, outpatient visits nationwide have remained rather constant at 7.6 million with approximately 40 percent attributable to veterans with non-service-connected disabilities. Within the same time frame, outpatient visits in the State of Florida have dropped 12.3 percent, from 74,652 per month to 65,403, and the treatment of veterans with nonservice-connected disabilities has fallen from 30.8 percent of the workload to 24.5 percent, of from 23,062 per month to 16,000. This, in a state experiencing an influx of more than 3,000 veterans each month. The answer is quite obvious. An increasing number of veterans with nonservice-connected disabilities are being denied care, and as Dr. Houston stated with respect to Fort Myers, ". . . the inability to provide VA care to service-connected veterans, the highest priority group, in the foreseeable future is a possibility . . ." This is an intolerable situation. In view of the foregoing, and that which is quite evident, we believe for the Administrator of Veterans Affairs to include a major construction project at Lake City on his revalidation list is, in our opinion, both inexcusable and insensitive to the needs of veterans.

Mr. Chairman, there is no doubt VA health-care personnel are dedicated and provide high-quality medical care to the largest number of patients possible within apportioned budgetary and personnel constraints. Unfortunately, the VA has been subjected to repeated inadequate budgets over a protracted period. In comparing VA budgets with those for Human Resources programs over the past 33 years, House Veterans' Affairs Committee Print No. 74 of March 15, 1982, quite clearly stated the problem and the pertinent portion is herein quoted: ". . . Federal outlays for veterans' benefits and services have increased only three-fold compared to 291-fold for Health; 89-fold for Education, Training and Social Services; and 55-fold for Income Security." During this 33-year period the veteran population increased by 13.1 million; 4.6 million from the Korean Conflict and 8.5 million Vietnam-era veterans. In the last ten years, the VA budget has fallen from 4.9 percent of the Federal budget in outlays to a projected 3.1 percent for the fiscal year 1983 in S. Con. Res. 92 as agreed to by the conferees.

If the Veterans Administration is to provide the health care envisioned by Congress and mandated by law to veterans with service-connected disabilities and those in need with nonservice-connected disabilities, there is no question but that resources in the Sun-Belt States, and Florida in particular, must be increased. By this I do not mean funds and personnel should be siphoned off from other states facing the same overload problem but to a lesser degree, but, rather, the VA's portion of the Federal budget should be increased and not constantly decreased as it has been. The above-cited Committee Print graphically shows that veterans' health care is not breaking the budget.

In conclusion, and in the opinion of the VFW, spending priorities are out of kilter. We surely owe more to the veterans who have made this nation secure than to those who have made little or no contribution of any kind.

This concludes my testimony and I will be happy to respond to any questions you may have at this time.

THE AMERICAN LEGION,
Washington, D.C., June 23, 1982.

Hon. RONALD M. MOTTL,
Chairman, Subcommittee on Hospitals and Health Care, House Veterans Affairs Committee, Cannon House Office Building, Washington, D.C.

DEAR CHAIRMAN MOTTL: We have enclosed several copies of a statement which we request be inserted as part of the permanent record for your Subcommittee's hearing on July 23 regarding the health care needs of veterans in Florida.

Current information convincingly reveals that the dramatic influx of veterans to Florida is severely straining VA medical resources in that state. Obviously, this situation cannot be properly addressed without the expenditure of federal monies to construct new facilities and expand present ones. However, recently enacted legislation (Public Law 97-174) may offer an interim solution and may contribute to a permanent solution to the problem encountered by the VA medical system in Florida.

We believe it would be appropriate for your Subcommittee to identify all military medical facilities currently located in that state and to subsequently establish the daily patient load in these facilities. If it can be determined that any or all of these military facilities are not operating at full capacity, then due consideration should be given to treatment of veterans under provisions of Public Law 97-174.

Mr. Chairman, The American Legion clearly recognizes that VA medical facilities in Florida are currently required to operate far beyond their respective capacities and we stand ready to help you in any way that we can.

Sincerely,

E. PHILIP RIGGIN,
Director, National Legislative Commission.

Enclosures.

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion appreciates this opportunity to present its views on the provision of health care and medical services, particularly on an outpatient or ambulatory basis, to veterans in the State of Florida and other states in the Sunbelt.

It must be stated at the outset that it is a proven fact that ambulatory care is more cost-effective than inpatient care. This is the trend clearly established in the private sector, which through its clinics and emergency rooms is doing more and more health care delivery on an outpatient basis in an increasing effort to control the rapidly escalating costs of health care delivery. What is true for the private sector is equally true for VA.

The last available Report of the Administrator of Veterans Affairs, the Report for fiscal year 1980, shows that during that year, VA operated 226 outpatient clinics, in which it provided 15.8 million visits, in addition to 2.2 million visits made to private physicians authorized on a fee-for-service basis.

In his Budget Message to the Congress in February 1982, the President requested funding for 18 million outpatient visits for fiscal year 1983. This projected increase indicates the increasing level of demand for service being made by the enlarged and aging veteran population.

In its Report for fiscal year 1980 VA also says: An increasing number of therapeutic procedures also are performed in ambulatory settings, including moderately complex surgery, cancer chemotherapy, and the treatment of mental illness. The simple fact is that it is much more economical to treat a patient on an outpatient basis that to admit him to a hospital. This was the forward thinking that led the Congress, through its Veterans Affairs Committees, and with the support of The American Legion to develop the provisions of Public Law 93-82, the Veterans Health Care Expansion Act of 1973, which essentially established the VA Ambulatory Care Program as it is today. That law opened up a whole new approach to health care delivery for VA. The new direction has resulted in provision of better care to an ever-increasing number of veterans who need and apply for such care. Problems have developed from the failure to adequately fund this innovative approach to the practice of medicine. But, the point is that regardless of how much the cost of the VA Ambulatory Care Program has escalated, that cost has been far less than would have been incurred without the Ambulatory Care Program, which would have resulted in the hospitalization of multiple thousands more sick and disabled veterans. In this context, it must be borne in mind also, that the escalating cost of ambulatory care in VA simply mirrors the experience of the private sector during a series of

years marked by rapidly expanding inflation that in 1980 raged at a level of almost 13 percent.

Having set forth this basis for American Legion support for the VA Ambulatory Care Program, we shall not address the specific issue under consideration today, beginning with the demographic trends currently impacting on the veteran population. As with the population generally, the trend is toward the Sunbelt. The demographic profile of the veteran population is rapdily changing as increasing numbers of mostly older veterans move southward to spend their retirement years. However, it must be said that younger veterans are also moving south in increasing numbers as industry and commerce moves in that direction from the Midwest and Northeast.

The result of these changes is an increasing amount of pressure on VA facilities in the Sunbelt states. The classic example is Florida which is experiencing an increase in its mostly older veteran population ranging to 7,000 per month. The impact of this veteran migration on VA health care facilities in Florida has been massive.

Without exception, the VA health care facilities in Florida are carrying patient loads they were never designed to accommodate. The Federal Government has to face up to that fact and make adjustments accordingly. It is our understanding a new clinic is in the process of being opened in the Ft. Lauderdale area. There is a new clinic in Broward County, north of Miami. Other things are being done, but much more needs to be done if VA is to meet its responsibilities to the veteran population is Florida. And that same situation prevails in other southern areas of the nation. According to available statistics, between September 1978 and September 1981, the veteran population in the following Sunbelt states increased by the numbers indicated: Florida, 118,000; Arizona, 26,000; Texas, 24,000; Arkansas, 9,000; South Carolina, 6,000; and Georgia, 5,000.

An American Legion Field Representative completed a site visit to VAMC Miami, Florida in August 1981. The following observations are included in his report: "According to the Director, funding and staffing for VAMC Miami have historically been inadequate. Consequently, this facility is unable to meet the demands of the 470,000 plus veterans in the immediate catchment area.

"Actual outpatient visits have exceeded funded visits by more than 30,000 for several years. Exact costs for absorbing these additional visits could not be determined, but is expected to total about 1.5 million dollars per year."

A Field Representative completed a site visit to VAMC Little Rock, Arkansas in March of this year. He ascertained that the Ambulatory Care Program at Little Rock VAMC recorded 161,729 visits during fiscal year 1981. In fiscal year 1982, through February, the clinics recorded 64,349 visits. The simple fact is that in such places as Florida, Arkansas, Arizona, some parts of Texas, and other places in the Sunbelt, the volume of demand for services is increasing in multiples. Our perception is that VA is not ready for this influx of veterans. It is trying, and doing its best with the resources available, but these resources need to be increased—in a major way and rapidly.

The American Legion believes what is needed now is for Congress to mandate a study by an appropriate authority, possessing the necessary expertise, of the current and anticipated demographic profile of the veteran population, and the present capacity of VA to provide medical services to that population in its Ambulatory Care program. We believe the study should identify the amount and location of resources, and how these need to be modified now and for the foreseeable future to meet demands. For example, if the older veteran population is migrating southward—which it is—then it seems clear that greater resources must be allocated to that part of the nation, and concomitantly there should be a moderation of demand for services in some other parts of the country. This study, simply defined in this statement, would, of course, be complex and detailed in its findings. It might result in major readjustments within the VA Department of Medicine and Surgery. We are aware that VA is in fact undertaking certain studies of its own that might add to the fund of knowledge needed on this subject of ambulatory care. However, it is our suggestion that Congress should perhaps not rely entirely on VA to carry out such a study, but should add to the VA's effort, information that it obtains through its legislative authority, independently arrived at, and providing guidance as to where funding should be directed, and what and where resources should be acquired, to enable VA to meet its legislatively defined mission.

The American Legion categorically supports the fourfold mission of the Veterans Administration in the field of health care, as that mission is presently legislatively stated: (1) to provide medical care for sick and disabled veterans; (2) to participate in health manpower training for the nation; (3) to participate in basic research, and, (4) to act as the principal contingency back-up resource to the military medical care

program in case of national emergency. We further accept what appears to be fact, that ambulatory care, in individual cases is better for the patient, and cost-effective for the provider. That fact is now accepted by medical science for both the public and private sectors. We understand that a study such as we here suggest may result in a reorganization of VA's Department of Medicine and Surgery in its field operations. If a reorganization needs to be done, then it should be done, and the sooner the better. It is essential now, for the Veterans Administration to prepare itself to care for its clientele for the balance of the Twentieth Century and into the next Century.

The American Legion is sure that a reorganization of VA's health care delivery system to maximize ambulatory care, thus reserving in-patient care for those who need it, is a cost-effective way for VA to fulfull its mission, the cost of the Ambulatory Care Program will no doubt increase. But the savings will be immediately realized in restrained demand on bed services within the VA system.

Mr. Chairman, that concludes our statement. We thank the Subcommittee for receiving our views.

Testimony of Representative L. A. "Skip" Bafalis

Mr. Chairman, I appreciate the opportunity to share my views with you and the Members of your Subcommittee regarding the problems of health care for veterans in the State of Florida. There are two serious problems I want to address today: (1) The need for expanded nursing home units and (2) the need for long-term psychiatric care facilities in Florida.

Recent statistics show that over the past ten years the Sunbelt States, of which Florida is one, experienced dramatic increases in population. The total population of Florida alone increased 43.4 percent since 1970. The number of veterans residing in Florida also increased and at almost the same rate—40 percent. Furthermore, approximately three to five thousand veterans move to Florida each month, and this trend is expected to continue for decades to come. In fact, the State's 1.3 million veterans population is predicted to double by the year 2000.

Not only are more retired veterans moving to Florida but they are also living longer. The Veterans Administration's Medical Center at Bay Pines in St. Petersburg, Florida, recently doubled the size of its nursing home units, but this is not adequate to meet the pressing demands of the tremendous increase in the number of veterans needing full-time nursing care. Already there is a multi-year waiting list for a limited number of beds, and unless the Veterans Administration expands the nursing home care facilities in Florida within its own structure the problem will reach crisis proportions.

As the law is now written, aging veterans with limited resources who are unable to be cared for at a VA nursing home but need full-time nursing attention are placed in a private nursing home for six months. During this time it is up to the patient's spouse or family to locate other resources to pay the full monthly cost of private nursing care. However, all too familiar is the case of the spouse being unable to finance the costs on her own due to her our limited income and being left with two alternatives: (1) Bring her husband home and obtain whatever low-cost home health care services she can, or (2) hope that her husband's doctor will have enough sympathy to readmit her husband to the hospital for a few weeks in order to make him eligible for another six-month stay in a VA-supported nursing home. It is unthinkable that we must impose this kind of hardship and anxiety on families of American veterans.

By expanding nursing home facilities in the State of Florida, we would preserve the dignity of those who so faithfully served this country and at the same time accomplish a number of objectives. Clearly, we would accrue some savings—however small—by operating at lower cost VA nursing homes rather than placing our veterans in private nursing care. More important, though, we would free up hospital beds by eliminating the need for a doctor's periodic review of a patient whose condition is terminal.

With the anticipated growth in Florida's veteran population—particularly retired veterans—it would be unwise not to plan ahead and make certain that adequate nursing home care is available. Therefore, I heartily support all efforts to meet the needs of the years ahead and expand current nursing home care within the Veterans Administration in Florida.

My second concern with the present system of health care for Florida veterans is the availability of long-term psychiatric care. As I am sure you are aware, there is no long-term psychiatric care facility in Florida. A large amount of the VA case-

work handled by my office relates specifically to problems of World War II and Vietnam Veterans needing quality long-term psychiatric care. The closest hospital for psychiatric patients living in Florida is in either Augusta, Georgia, or Tuscaloosa, Alabama. As a result, many families will choose to forego professional care through the Veterans Administration altogether so as not to be separated from their loved ones. And it is a well-known fact that for most psychiatric patients, their only contact with the "outside world" is through periodic visits from their families.

Furthermore, I think it is accurate to assume that the anticipated increase in the veteran population in Florida will also mean an increase in the number of cases of veterans with psychiatric disabilities. Again, to prepare for this surge of medical needs and to remedy the current absence of long-term psychiatric care facilities in Florida, I support all efforts to make permanently available—either by expanding an existing medical center or by constructing a new facility, centrally located in the State—adequate services for veterans requiring extensive psychiatric care.

Thank you, Mr. Chairman, for allowing me to address these concerns on behalf of my constituents and all veterans in the State of Florida. I am particularly encouraged that your Subcommittee has taken such a serious interest in the current and future problems of health care for Florida veterans that we might provide them with the best possible medical care in return for their loyal service to this country.

STATE OF FLORIDA,
DEPARTMENT OF VETERAN AND COMMUNITY AFFAIRS,
DIVISION OF VETERANS AFFAIRS,
June 2, 1982.

Congressman RONALD M. MOTTL,
Chairman, Subcommittee on Hospitals and Health Care, U.S. House of Representatives, Cannon House Office Building, Washington, D.C.

DEAR CONGRESSMAN MOTTL: Thank you for your invitation of May 28, 1982, to appear before the Subcommittee on Hospitals and Health Care, on June 23, 1982, at 9:00 a.m., in the Cannon House Office Building.

Although I will not be able to attend due to a previous commitment, I have prepared a statement on hospital care and medical services to veterans in the State of Florida.

Florida is medical District 12, with five (5) VA Medical Centers providing primary, secondary, and tertiary care to veterans in Florida and South Georgia. The district's three (3) major teaching hospitals are affiliated with the State's three (3) schools of medicine. The other two (2) hospitals have varying degrees of affiliation. In addition to the five (5) VA Medical Centers, there are six (6) satellite Outpatient Clinics in operation. The district provides fee-basis medical, dental, pharmacy and non-VA hospitalization services for all of Florida. This is the largest fee-basis program in the VA System. With the exception of long-term psychiatric care, most of the recognized special medical programs exist at one or several of the District Health Care Facilities.

Within Medical District 12, there are 3,049 authorized inpatient beds serving 1.4 million veterans in the State of Florida, as well as 19 counties in South Georgia. Medical District 12 consists of 59 of the 67 counties in the State of Florida. The outpatient workload for Fiscal Year 1980 was 782,043 actual visits. By 1990, the district has a projected need of its veteran population with an additional 2,392 inpatient facility beds, including 371 long-term psychiatric care beds and an additional 685,034 outpatient visits.

The VA also provides quality health care to eligible veterans within the district and plans to maintain this delivery capability through 1990.

The Va Medical Centers serving Florida are providing quality health care within their budget limitations. If any funds for the medical program are curtailed, that of course, would mean not only less-than-quality health care for eligible veterans, but a decline of the VA Hospital System. We know that the nursing staff has lost qualified personnel because of the private sector being able to provide more attractive offers in their recruitment of nurses. The VA has recently been provided with a Scholarship Program which should help to recruit nurses to meet the needs in the Medical Centers, and to bring them up to full staff.

The VA Medical Program has been one of providing the best care for those who have served their country. I think that we are "missing the boat" if the VA cannot provide care through a reduction of funding, especially to the aging veteran.

By the year 2000, the veteran population is expected to increase by 100 percent, although the total veteran population in the nation decreases by 10 percent. This means that there will be projected, a 550 percent increase in veterans ages 65 to 74,

for Medical District 12, while only a 168 percent increase is projected in this age group, nationally; there will be a 775 percent increase in veterans over 75, while only a 335 percent increase in this age group is projected, nationally. The District currently serves a higher-than-the-national-average number of veterans that are over 65 years of age, which includes veterans who receive Housebound or Aid and Attendance Pension, and the service connected veterans. There are approximately 3,000 to 5,000 veterans moving to Florida monthly, and the trend is to move to the Sunbelt Area, of which Florida is probably the fastest growing area in veteran population in the South.

In order to meet the need for services, there will have to be funding provided to staff the required physicians and other supporting staff, taking into consideration the aging veteran. The VA has treated our non-service connected aging veterans for many, many years, and the veteran has become dependent upon the best health care system we feel that the VA provides. However, it has now come to the point that these non-service connected veterans are being told that they cannot be treated anymore, and that they will have to go to their private physician or other health care facilities and pay for the services provided. Most of these older veterans cannot afford this type of care, and the only care that they can receive is through the VA System. The needs of these veterans should not be forgotten, and it is a very serious concern to me that our nation has an obligation to continuing providing services for our veterans. Cutting funds in the Medical Program is not the answer, but rather, providing the necessary funding to take care of their needs.

There is also a need for long-term psychiatric beds for the State of Florida. The VA now has 523 Acute Care psychiatric beds, with an average occupancy rate of 83.4 percent. The projection for 1990 would indicate the need for 561 Acute Care beds and 371 Extended Care psychiatric beds. An official VA Central Office study completed in May, 1976, indicated a need in this Medical District by 1985, of 374 long-term psychiatric beds, and these are divided with 200 at Gainesville; 64 at Bay Pines, and 110 at Miami.

In the Outpatient and Ambulatory Care, the projects for 1990 for Medical District 12 are 1,467,067, which is an increase over the 1980 Actual Visits. Recent legislation has provided care, including Dental and other related Outpatient Services, for the veterans, and the need to address the growing population is urgent. The VA cannot provide quality care with limited staffing without increasing the cost to provide that care.

Nursing Home Care is another concern because the VA has a limited number of beds available to our aging veterans. It is very difficult to find a vacant bed in which to place one of our veterans with no family to care for him, but who needs the care of a Nursing Home that the VA can provide. He is a veteran who is without resources; one who cannot provide monies to care for himself in a Community Nursing Home, without VA assistance. These require your attention now, so that their needs can be met.

My suggestion for meeting these needs would be to continue funding the hospitals, which includes sufficient amounts to cover the needed staffing, and legislation to provide care for the aging veterans. Congress has provided outpatient treatment for all of the World War I veterans, and by the time 1990 arrives, the World War II veterans will be rapidly reaching the same age and will be having some of the same problems the World War I veterans now have. The need is to face these problems now.

I think that there is a need to look at the Outpatient Treatment Program in providing services to the service connected veteran, but also look at the non-service connected veteran, especially in Florida, for whom the VA has provided services for many years; but now the VA is telling them that they are not entitled to further outpatient treatment. These are my concerns.

I appreciate the opportunity of providing testimony to the Sub-Committee, and hope that you will be able to provide the funds that will continue our quality health care in the VA System.

Very truly yours,

ROBERT R. ERSKINE, *Director.*

STATEMENT OF HON. DANTE B. FASCELL OF FLORIDA

Mr. Chairman, I appreciate having the opportunity to participate in these important hearings on the care being provided to veterans in Florida at Veterans' Administration hospitals and medical facilities. You and the other members of the Sub-

committee are to be commended on your commitment to veterans and your continuing efforts to ensure their welfare.

The rapid growth of Florida's large population of veterans makes it increasingly important for us to monitor and evaluate the services being offered to ensure that the needs of veterans are being met and that funds are allocated in the proper proportions. These are tasks that require close cooperation with officials of the Veterans Administration, veterans and the groups representing them. Your review today of the situation in Florida is an essential part of this collaborative endeavor and an important communication tool.

I have been encouraged by the willingness of officials at the Veterans' Administration to identify and correct deficiencies in services to veterans. We are fortunate to have so many dedicated people at the VA. I trust that since we share a common goal, that is providing the best possible medical care to veterans in the most efficient manner possible, we can continue to work together to develop solutions to existing problems.

In my own district in South Florida, the Veterans' Administration Medical Center in Miami is experiencing a steadily increasing demand for services at a facility that is already over taxed in terms of space and personnel. It is my understanding that plans are in progress to construct additional treatment areas there for radiology and radiation therapy and for treatment of spinal injuries. Such improvements will certainly provide important relief and enable the medical teams to give better care in a shorter period of time. I hope that these plans can be implemented as promptly as possible because the facilities are desperately needed.

In addition to adding treatment areas, we must also ensure that the medical center has sufficient nurses and support staff to accommodate the needs of a growing veteran population. Efforts now in progress to attract top professional nurses are commendable and should be continued; however, we must also make the best possible use of the personnel we now have. We can do so by training support staff to deal more sympathetically and effectively with patients and by continuing to seek ways to improve the processing procedures.

The shortage of psychiatric and nursing home care in Florida is also of considerable concern to me. I know that the VA is making progress in providing this care, but we must not lose sight of its importance. This must remain a high priority in our long range planning.

Today more than ever, we must make the best possible use of every government dollar. Carefully coordinated spending programs are vital, and, in order to provide the excellent health care our veterans deserve, we must use every management tool at our disposal to develop plans that will work. From construction of new facilities to maintaining staffing levels and analyzing procedures, we can prepare for the greater demands we know the future will bring in Florida. I am confident we will do so in view of the interest and concern demonstrated by this Subcommittee. Thank you for the opportunity to express my interest in the welfare of Florida veterans.

STATEMENT OF HON. WILLIAM LEHMAN

Mr. Chairman, I am very pleased that you have scheduled a hearing on Veterans Administration hospital care and medical services in the state of Florida. Our congressional office frequently receives complaints from veterans residing in the Thirteenth Congressional District regarding the care provided at the VA hospital in Miami. This is especially true of the nonservice-connected veterans who turn to the VA for help.

I wish to commend your subcommittee for the interest you have shown in the problems experienced by Florida veterans. Congressman Dan Mica, as a member of your subcommittee, has done an outstanding job in representing the veterans of our state and you have certainly been responsive to our concerns.

Following a meeting held with members of the Disabled American Veterans in my district office on March 29, I set up a meeting with south Florida congressional offices and representatives from the VA here in Washington on May 6 in order to discuss the many complaints we receive from our veterans. The Veterans Administration was most cooperative in responding to our questions and provided us with information concerning their future plans for improving health care for veterans in Florida.

Mr. Chairman, the quality of care in our area has suffered primarily because of the demographics of our region. Florida has a higher proportion of elderly than other parts of the country. Even as our population of long-time residents ages, more and more elderly from northern states move to Florida. Many of the veterans who

have moved to Miami are astounded by the difference in the type of care they receive at our VA hospital compared to the care they received in their home states. Another problem unique to Florida is the large number of persons who reside there only during the winter months. They do not always show up in census counts, but they show up at the Miami VA hospital if they have health problems.

The Veterans Administration has already lost ground in its efforts to care for all these people. The burden will become even heavier as the years go by, and I am convinced that the VA should receive the resources and guidance they need in order to at least provide comparable care to that received by veterans in other parts of the country.

I would like to include in the record a summary of the discussion held at our May 6 meeting. In it we have listed the most frequent complaints of veterans in our area and the VA's responses. The committee will see from this summary that the VA does seem to be making a sincere effort to provide better service, but it will take a lot of time and money before we can be satisfied with the care our Florida veterans receive.

A meeting to discuss the problems faced by veterans seeking health care from the Veterans Administration in south Florida was held on May 6, 1982, at 10:45 a.m. in Room H-139 of the Capitol.

In addition to Congressman Lehman and Congressman Mica, staff from the offices of Congressmen Fascell, Pepper and Shaw were present. Mr. Steve Edmiston of the Washington Office of the DAV also attended. Representing the Veterans Administration were Dr. Earl Brown, Jr., Acting Assistant Deputy Chief Medical Director; Donald B. Thompson, Regional Director for the Southeastern Region; James S. Must, Deputy Regional Director for the Southeastern Region; William Ramsey, Legislative Affairs staff of the Department of Medicine and Surgery; Ralph Ibson, VA Office of General Counsel; and Robert "Corky" Coleman, VA Congressional Affairs.

A list of common complaints received by congressional offices served as the basis for discussion.

(1) The first problem discussed was the lack of resources to provide care for nonservice-connected veterans at the Miami VA Hospital. Of immediate concern to veterans was a notice which had been posted stating that nonservice-connected veterans and veterans with less than 50 percent service connection seeking care for an NSC condition could receive followup outpatient treatment following hospitalization for a period not to exceed three months, after which they would have to seek care elsewhere. Exceptions to this policy were made for World War I veterans, veterans whose disability was rated at 50 percent or more, and veterans receiving aid and attendance or housebound benefits.

The VA representatives stated categorically that such a policy was not in effect and that the Miami Medical Center had been directed not to post such a notice. While service-connected veterans do receive preference for their service-connected conditions and those who are rated 50 percent or more service-connected receive care for any condition, nonservice-connected veterans and those veterans who are rated less than 50 percent service-connected who seek care for NSC conditions continue to receive care at the Miami Medical Center within available resources and according to the legislated priorities for care.

The VA further recognizes that the veterans population in south Florida has growing medical needs that the facilities' current funding level cannot adequately handle. The VA has, therefore, added $1 million and 13,500 outpatient staff visits to Miami's budget allocation beginning in fiscal year 1983. Twenty full-time employees are being added to the staff.

In addition, plans for facility expansion are being made. Outpatient services should be improved by the construction of a $49 million Ambulatory Care and Spinal Cord Injury unit. The current outpatient clinic was designed to handle 135 patients per day. It now services 850.

Expansion of the radiology department is included in Miami's Five-Year Facility Construction Plan. Presently, there are only nine X-ray rooms. This space is expected to be doubled when the expansion is completed.

(2) Veterans have also expressed concern about the lack of staff at the hospital. One congressional office had been told that the Miami hospital had fewer than 50 registered nurses. The VA representatives informed the congressmen and staff present at the meeting that in fact, 250 registered nurses were on duty at the Miami hospital. This is still less than the number needed to properly staff the hospital and a national recruitment campaign will begin soon. The VA noted, however, that there had been some improvement in the last year as nationally the number of beds closed due to nurse shortages had been reduced by 23 percent.

(3) Veterans who go to the Miami Medical Center for outpatient care are forced to wait long hours. The VA stated that waits in Miami are above the national average. The average time for a nonservice-connected veteran to complete his visit is two hours, 47 minutes. Part of this problem is due to insufficient facilities and part of it is due to a large number of veterans who come into the clinic on a walk-in basis rather than arranging an appointment. The VA hopes that the planned expansion of facilities will relieve veterans of such lengthy waits.

Veterans have found that their telephone calls to the Miami hospital take an inordinately long time to be answered. This problem too should be resolved in the near future as Miami is at the top of the list for the installation of a new phone system in fiscal year 1983.

(4) Veterans have also complained of VA staff attitudes which are often described as rude or indifferent. The VA has taken steps to resolve this problem through special training courses emphasizing courtesy, interpersonal relationships and transcultural skills. VAMC Miami employees have received 9,100 hours of such training.

The improvement and expansion of the present facilities should also have some positive effect on staff attitudes as some of the pressures related to overcrowding will be relieved.

(5) Some veterans had also complained that they had difficulty communicating with foreign-born doctors. The VA has reviewed the staffing at the Miami hospital and reported that most of these doctors are American citizens, all of whom have demonstrated English proficiency and have completed the necessary training courses to qualify them to be licensed and practice medicine in this country. The VA also noted that 10–12 percent of the veteran populaton in the Miami area is bilingual and the presence of bilingual staff provides better service for these veterans.

(6) Florida has no long-term psychiatric facility, thus imposing additional hardship on many veterans and their families. The VA reported that a new addition which will include 200 long-term psychiatric beds is being planned for construction at Gainesville. Also the construction of a new spinal cord injury unit at Miami will enable the VA to establish 42 additional psychiatric beds at the Miami VAMC.

(7) A replacement computer system is needed to improve the hospital's efficiency. Such a system is especially needed in the areas of scheduling and record-keeping. The VA plans to have a new system in place in 1983.

(8) Veterans have expressed concern about the understaffing of the VA nursing home in Miami. The nursing home has 120 beds, but only 90 of them are available for patient care despite a lengthy waiting list of veterans who need such care. The situation is the result of understaffing. The VA stated that it had miscalculated the additional staffing requirements of the nursing home. Steps are being taken to increase funding and staffing so as to gain full use of this unit. The VA also stated that an additional 120-bed nursing home unit is being planned for construction at Miami to be completed in 1986.